



STATE OF ARIZONA

JANET NAPOLITANO  
GOVERNOR

OFFICE OF THE GOVERNOR  
1700 WEST WASHINGTON STREET, PHOENIX, AZ 85007

MAIN PHONE: 602-542-4331  
FACSIMILE: 602-542-7601

March 7, 2006

Secretary Michael O. Leavitt  
Secretary of Health & Human Services  
Department of Health & Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Dear Secretary Leavitt:

It is my pleasure to request the extension of Arizona's Section 1115 Research and Demonstration Waiver for the period of October 1, 2007 through September 30, 2011, which will provide for the continuation of the Arizona Health Care Cost Containment System (AHCCCS), the State's Medicaid and SCHIP program. As I am sure you are aware, the AHCCCS program has the unique distinction of operating under the flexibility provided to States by the Section 1115 waiver process since its inception. The program has consistently demonstrated great success that has been well documented by numerous studies, reviews and audits.

The attached proposal demonstrates that AHCCCS has been able to offer quality care for members while containing costs. The most recent data from Kaiser indicates that Arizona has the fourth lowest per member costs of any Medicaid program in the country. I am most proud of the fact that Arizona has been able to achieve this cost containment while at the same time providing quality care to our members and fair reimbursement to providers. Arizona has done things the right way through utilization and medical management while offering an extensive integrated medical network.

The program enjoys sound support from providers, advocates, elected officials, members and the citizens of the State. The State has faced tremendous fiscal pressure over the past several years. When I came into office on January 1, 2003, I inherited a projected deficit of over \$1.0 billion in the upcoming fiscal year. These significant fiscal challenges were also occurring while the AHCCCS program experienced phenomenal growth. Given these pressures, it is a testament to the critical role of the program in Arizona that minimal changes were made to it during this time period.

It is important to point out that the majority of Arizona's 1115 Waiver proposal involves requests to renew existing authority to sustain a model that has a long history of effectively serving this state. Because new federal regulations have been adopted since the last time Arizona renewed its waiver, new authority must also be sought to continue the AHCCCS program in its current form. In addition, the State is seeking authority for new programs that could benefit the people of Arizona including an Employer Sponsored Insurance program and allowing reimbursement so that spouses can serve as paid caregivers to members of the Arizona Long Term Care System (ALTCS).

I appreciate the discussion and the support that we have already received from yourself and Dennis Smith with regards to the ALTCS program. I would ask that you continue to provide the entire AHCCCS program with the flexibility that is being requested in this proposal.

Medicaid and specifically AHCCCS are a success today because of the joint federal/state partnership that exists. I value the leadership you have provided in forming the Medicaid Commission and working to identify practices that best contain costs while offering quality care. Arizona supports these efforts and is interested in continuing to be a leader in this effort.

The continuation of the AHCCCS program in its current model and structure is a very high priority for my Administration. I look forward to any future discussions that may be necessary regarding the continuation of the program. I appreciate your and your staff's ongoing support.

Yours very truly,

A handwritten signature in black ink, appearing to read "Janet Napolitano", with a long horizontal flourish extending to the right.

Janet Napolitano  
Governor

# Arizona Health Care Cost Containment System

## **Section 1115 Research and Demonstration Waiver Renewal Proposal**

**Janet Napolitano, Governor  
Anthony D. Rodgers, Director**

**March 13, 2006**

# **TABLE OF CONTENTS**

<b>Executive Summary .....</b>	<b>3</b>
<b>Chapter I – The Environment .....</b>	<b>4</b>
<b>Chapter II – Program Administration.....</b>	<b>7</b>
<b>Chapter III – Eligibility.....</b>	<b>9</b>
<b>Chapter IV – Benefit Package .....</b>	<b>11</b>
<b>Chapter V – Delivery Network .....</b>	<b>13</b>
<b>Chapter VI – Access.....</b>	<b>17</b>
<b>Chapter VII – Quality .....</b>	<b>21</b>
<b>Chapter VIII – Finance .....</b>	<b>26</b>
<b>Chapter IX – Waiver / Expenditure Requests .....</b>	<b>27</b>
<b>Chapter X – Operational Protocols.....</b>	<b>40</b>
<b>Chapter XI – Evaluation Guidelines.....</b>	<b>60</b>
<b>Appendices</b>	

# Executive Summary

Arizona requests approval from the Centers for Medicare and Medicaid Services (CMS) to renew the current Arizona Health Care Cost Containment System (AHCCCS) 1115 Research and Demonstration Waiver through September 30, 2011. With CMS approval, AHCCCS will continue to operate its cost effective and successful managed care model. This proposal will enable Arizona to continue to provide high quality health care to Arizonans.

AHCCCS is a stable, mature, managed care program with a proven infrastructure and more than 22 years of experience in operating managed care programs. The demonstration project AHCCCS seeks to renew will allow Arizona to continue contributing to the goals of providing quality health care to members in a mainstream environment, while reducing the rate of uninsured and maintaining a cost effective program. In addition to renewing all current waiver authority, AHCCCS is seeking to implement the following:

- Authority to implement an Employer Sponsored Insurance (ESI) program. The ESI program would allow the state to provide premium subsidies for the purchase of employer sponsored health insurance for specified individuals. The ESI program would be available statewide to eligible employees who work for participating businesses with no more than 25 employees.
- Authority to reimburse spouses of long term care members to serve as paid caregivers. The purpose of the program is to provide assistance for members who require long term care, so members can remain in their own home, contributing to the quality of life for the member while creating savings by reducing higher costs associated with institutionalization.
- Authority related to Medicaid managed care requirements regarding choice of coverage, disenrollment and reenrollment policies. Approval of these requests would allow for the continued success of the current Arizona model.

---

# I. The Environment

## A. Overview of the Current System

AHCCCS has operated as a statewide, managed care 1115 Research and Demonstration Medicaid program since 1982. A historical overview is attached as Appendix I. This original demonstration has allowed Arizona to operate a statewide, managed care system that requires almost all members to enroll in a contracted Health Plan for acute care services. AHCCCS makes prospective capitation payments to Health Plans for each enrolled member.

Not long after the original implementation of the waiver, the Arizona Legislature added long term care benefits through the Arizona Long Term Care System (ALTCS). The ALTCS program has been successful in providing quality care and offering community based placements and support services in lieu of institutional care for the elderly, physically disabled, and developmentally disabled populations. ALTCS provides services coordinated by various Program Contractors. Similar to the acute care program, AHCCCS makes prospective capitation payments to Program Contractors for each enrolled member.

In May of 1998, the Arizona Legislature authorized the implementation of a stand-alone Title XXI State Children's Health Insurance Program (SCHIP), referred to in Arizona as the KidsCare Program. KidsCare was implemented in November of 1998. Children under the age of 19 may qualify for the program if their family income meets specified income standards.

The two populations that are not required to enroll in a Health Plan or Program Contractor are Native Americans and individuals who receive services through the Federal Emergency Services program (FES). Native Americans in Arizona who are eligible for acute care services may opt to receive their services either through the Indian Health Service (IHS) or through an AHCCCS contracted Health Plan. Similarly, for long term care services, Native Americans may choose to obtain their services either through an AHCCCS Program Contractor or through a Fee-For-Service (FFS) delivery system by enrolling with a tribal or other contracted case management provider. In contrast, individuals who receive emergency services through the FES do not have the option of enrolling in a Health Plan. These individuals receive all services on a FFS basis.

AHCCCS has been evaluated by federal agencies, including the United States Government Accountability Office (GAO), private firms, and contractors hired by CMS. Reports have been positive and have praised various components of the program, including the quality of care and the overall cost-effectiveness when compared with traditional FFS programs in other states.

In addition, AHCCCS has received numerous commendations and awards over the years. Some of these include the Leadership Award for Medical Quality from the American College of Medical Quality, a Health Care Financing Association (HCFA) National Customer Service Award for collaboration with Native Americans, the Council of State Government Award for Eligibility Fraud Prevention Program, and *Health Affairs* cited AHCCCS as one of the few prudent purchasers of health care in the nation.

AHCCCS has also been looked to as a model for others across the nation. The agency was recently asked to present testimony before Congress on methods to improve the management of Medicaid and health care programs. On May 9, 2005, Anthony Rodgers, the Director of AHCCCS, made a presentation on the success of AHCCCS to staff of the United States House Energy and Commerce Committee. On June 22, 2005 he was invited to appear before the Health Subcommittee to testify about AHCCCS' success related to "Medicaid Prescription Drugs: Examining Options for Payment Reform." While the presentation was focused on Arizona's management of the prescription drug benefit, testimony was solicited on a variety of other successes accomplished by the agency. On October 27, 2005, Director Rodgers was invited to share Arizona's successful results with the Medicaid Commission recently appointed by Secretary Leavitt. The agenda referred to Arizona's session as "Best Practices on Program Innovation Through an 1115 Waiver." The agency is proud that Arizona's model is looked to as a roadmap for success.

## **B. Legislation**

With the exception of the Employer Sponsored Insurance (ESI) proposal that is included with this renewal request, AHCCCS is not seeking legislation on any issues related to the demonstration. Implementation of the ESI Program requires legislative authority being sought during the 2006 legislative session.

While AHCCCS did not seek legislation related to the ALTCS cost sharing proposal submitted to CMS in 2003, it is legislation that was passed in 2003 that requires this proposal. Specifically, A.R.S. §36-2939(G) requires AHCCCS to implement cost sharing measures for specified ALTCS members with family income exceeding 400% of the Federal Poverty Level.

## **C. Public Notice/ Input from Public Agencies and Advocates**

The AHCCCS plan for public notice and input from public agencies and advocates exceeds public notice requirements as provided in the Federal Register, 59 FR §49249(VII). Three public hearings were hosted across the state to encourage public comment. Stakeholders, including advocacy groups, Health Plans, Program Contractors, provider groups, and members and staff of the legislature were invited to participate in the informational briefings. AHCCCS also invited all Arizona tribal

governments to participate in the hearings. In addition, presentations were provided to the Advisory Council on Indian Health Care, to attendees at the Health Session of the annual Indian Nation's Day, and to a group of Indian Health Service (IHS) providers. Additionally, AHCCCS presented its waiver renewal submission to the State Medicaid Advisory Committee. AHCCCS also posted a working copy of this renewal proposal on the agency website. Appendix II contains letters in support of the program received from various stakeholders.

#### **D. State Budget**

In fiscal year 2006, the state of Arizona is expected to experience a budget surplus. With this in mind, the financial outlook of the current Medicaid program is positive. It is expected that the state will sustain adequate financing for the life of the waiver.

---

## II. Program Administration

### A. Organizational Structure

AHCCCS has developed an organizational structure that effectively administers and monitors the demonstration. There are more than 1,300 full-time positions throughout the agency. The agency is divided into the following six divisions: Division of Business and Finance, Division of Member Services, Division of Health Care Management, Division of Fee-For-Service Management, Information Services Division, and the Office of the Director. An agency organizational chart is attached as Appendix III.

Each agency division plays a role in managing Arizona's demonstration. However, the Division of Health Care Management, in conjunction with the Office of the Director, has a unique responsibility for managing the relationship with our Health Plans and Program Contractors. The Division of Health Care Management is organized to focus on areas such as Quality Management, Maternal and Child Health, Contract Compliance, and Financial Analysis. Other areas that contribute greatly to maintaining quality in the agency are the Office of Program Integrity and the Office of Legal Assistance. Both of these Offices are managed as part of the Office of the Director.

### B. Contractual Relationships

Arizona's demonstration relies heavily on the partnership between AHCCCS and private and public managed care contracted Health Plans and Program Contractors. Health Plans are the Managed Care Organizations contracted to serve the AHCCCS acute care population, while Program Contractors are the Managed Care Organizations that serve the ALTCS members. Both the Health Plans and the Program Contractors play a critical role in Arizona's Medicaid model because they are responsible for delivery of services to members. The partnerships allow members to be mainstreamed into private-sector provider offices across the state. AHCCCS conducts a competitive bid process and performs Operational and Financial Reviews of the Health Plans and Program Contractors. Additionally, AHCCCS regularly monitors contractually required deliverables to ensure compliance with Medicaid managed care regulations, contract requirements, and quality of care standards.

In May 2003, AHCCCS awarded contracts to eight acute Health Plans for a three-year period beginning October 1, 2003. The contracts also provide for two one-year renewal periods. Most acute care contracts are awarded by Geographic Service Area (GSA), of which there are seven. (Appendix IV includes the acute GSA map.) In

addition, AHCCCS awards contracts on a non-competitive basis to the Comprehensive Medical and Dental Program, a Managed Care Organization, and the Children's Rehabilitative Services Administration, a Prepaid Inpatient Health Plan for acute and long term care members.

Currently, there are six Program Contractors that serve elderly and physically disabled members. In 2006, AHCCCS issued a Request for Proposals (RFP) for the ALTCS Program. The new contracts will be effective starting with the contract year beginning on October 1, 2006. With one exception, ALTCS contracts are awarded using the same GSA system as the acute care program. (Appendix IV includes the ALTCS GSA map.) Per Arizona Revised Statutes, an exception is made for the contract with the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD). ALTCS services for persons who are developmentally disabled are delivered by DDD, a Managed Care Organization, under a non-competitive contract and a capitation arrangement with AHCCCS. DDD is contractually required to comply with the same requirements as other Program Contractors.

Per Arizona Revised Statutes, behavioral health services for all acute members are administered under contract with the Arizona Department of Health Services (ADHS). ADHS receives federal funding from AHCCCS to operate the Title XIX and Title XXI behavioral health programs through Behavioral Health Services, a Prepaid Inpatient Health Plan that services acute members. ADHS subcontracts with Regional Behavioral Health Authorities (RBHAs) and tribal RBHAs to provide services. While members of acute programs who utilize behavioral health services through the RBHAs do not have a choice of managed care entities for behavioral health services, they do have a choice of providers once enrolled with a RBHA. ALTCS members receive their behavioral health services directly through the Program Contractors.

AHCCCS also joined efforts with tribal governments for the administration and delivery of long term care services to Native Americans. Seven tribal governments have signed intergovernmental agreements for the delivery of long term care case management services under the ALTCS program. In addition, AHCCCS has a contract with the Native American Community Health Center (NACHC) to provide case management services to on-reservation tribal ALTCS members whose tribes do not have an agreement with AHCCCS.

---

## III. Eligibility

Arizona seeks no changes to eligibility requirements. Under this proposal all current AHCCCS eligibility groups will continue to be covered under the demonstration. Each program has specific income and qualification requirements. The eligibility rules vary depending on the program, and will remain the same under the current waiver proposal. This demonstration proposal seeks continuance of the following waiver populations:

- The **Arizona Long Term Care System (ALTCS)** members are aged (65 and over), blind, or individuals with disabilities who need ongoing services at a nursing facility level of care. However, program participants do not have to reside in a nursing home. A majority of ALTCS members receive home and community based services as allowed in Arizona's demonstration. Arizona has expenditure authority to provide coverage to members whose income does not exceed 300% of the Supplemental Security Income (SSI) Federal Benefit Rate and who pass the medical Pre-Admission Screening (PAS) process.
- Members in the **Title XIX Waiver Group** are non-categorically linked individuals with adjusted net countable income at or below 100% of the FPL who are not otherwise eligible for Medicaid. Coverage was expanded to this population in 2001, after Arizona voters overwhelmingly approved the ballot initiative. Arizona has expenditure authority to provide coverage to this population.
- Members in the **Medical Expense Deduction (MED)** program do not qualify for other AHCCCS programs because their income is too high. However, they may be eligible for MED if they have medical expenses in the medical expense period that reduce their quarterly income to 40% of the FPL. Arizona has expenditure authority to provide coverage to this population.
- The **Health Insurance Flexibility and Accountability I (HIFA I)** population includes childless single adults and childless couples over the age of 18, with income between 40% and 100% of the FPL. Arizona has expenditure authority to utilize Title XXI funds to provide coverage to this population. Title XIX funds are used for this population if Title XXI funds are not available.
- The **Health Insurance Flexibility and Accountability II (HIFA II)** population includes eligible parents of KidsCare and/or SOBRA eligible children with income between 100% and 200% of the FPL. Arizona has

expenditure authority to utilize Title XXI funds to provide coverage for this population.

In addition to eligibility for the above-mentioned groups, Arizona's demonstration also authorizes several waivers that streamline the eligibility process, making the process more efficient. Arizona is seeking renewal of these waivers as discussed in more detail in Chapter IX. In addition, CMS has informed AHCCCS that authority to disregard interest and dividend income from excluded resources for determining ALTCS and SSI-MAO eligibility, requested by AHCCCS in March of 2005, will be made a part of this renewal request. While this may result in a small amount of individuals being made eligible who would otherwise not be eligible, the negligible fiscal impact is outweighed by the benefits of a more efficient eligibility determination process.

---

## IV. Benefit Package

Arizona seeks no restrictions to its current benefit packages. Under this proposal all current benefits will continue to be covered under the demonstration. All acute care members have access to the exact same benefit package no matter which Health Plan they choose to enroll with. Similarly, all ALTCS members have access to the exact same benefit package no matter which Program Contractor they choose to enroll with. Native Americans who choose to receive services through the IHS system also have access to these same benefits.

### A. Waiver Related Services

This proposal seeks continuance of the following waiver benefits:

#### Home and Community Based Services

Arizona's demonstration provides expenditure authority to cover Home and Community Based Services (HCBS) for ALTCS members. HCBS include home health, respite, attendant care, personal care, homemaker services, transportation, adult day treatment, home-delivered meals, and habilitation for those that are at risk of institutionalization.

#### Up to 24 Months of Family Planning Services

Arizona's demonstration provides expenditure authority to specifically cover family planning services for up to 24 months after birth for AHCCCS-eligible women who subsequently lose eligibility at 60 days postpartum.

#### Institution for Mental Diseases

Arizona's demonstration provides expenditure authority to cover specified stays in an Institution for Mental Diseases (IMD). Currently, reimbursement is provided for 21-64 year old members in an IMD for the first 30 days of the stay with an annual limit of 60 days.

This proposal does not seek continuance of the following expenditure authority:

#### Supported Employment Services Restriction

Arizona's current demonstration provides expenditure authority to cover supported employment services only for certain HCBS clients. Due to changes in federal regulations, these services are now available to more than just this limited group. In order to eliminate the restriction to HCBS members, Arizona is not seeking continuance of this expenditure authority. The benefit of Supported Employment Services will be available to all ALTCS members.

## **B. Behavioral Health Services**

Behavioral health services are provided for the evaluation and treatment for mental disorders and substance abuse. These services are carved out for members in acute programs and are managed by the Arizona Department of Health Services (ADHS). ALTCS members access this benefit through their Program Contractor. Waiver authority is being sought in this demonstration to continue Arizona's Behavioral Health Services model.

## **C. Cost Sharing**

Since the inception of AHCCCS, co-pays have been nominal with no co-pay for prescriptions, \$1 for physician office visits, and \$5 for non-emergency use of the emergency room. In 2003, the Arizona State Legislature instituted increased co-pays for certain AHCCCS members. In accordance with this legislative action, AHCCCS sought guidance from CMS to implement greater than nominal mandatory co-pays for Title XIX waiver groups. CMS informed AHCCCS that waiver authority was unnecessary but the cost sharing measures should be included in Arizona's Operational Protocols. When AHCCCS began implementation of these co-pays in the fall of 2003, a lawsuit was filed challenging the authority of AHCCCS to enforce the co-pays. A U.S. District Court issued an injunction and prevented implementation of cost sharing. To date, the injunction still governs in Arizona.

In 2003, the legislature also instituted cost sharing measures for specified ALTCS members with family income at or above 400% of the Federal Poverty Level. AHCCCS submitted a request to CMS in 2003 to implement cost sharing measures on this population. CMS has informed AHCCCS that this request will be considered as a part of this renewal proposal.

---

## V. Delivery Network

AHCCCS has operated as a statewide, managed care 1115 Research and Demonstration Medicaid program since 1982. The existing administrative infrastructure of the program coupled with the experience of the Health Plans and Program Contractors promote the delivery of quality health care services. The mainstreaming of members into the private physician sector was the direct result of a working partnership between AHCCCS and our Health Plans and Program Contractors. Mainstreaming members is a critical element in the success of the acute care program. The AHCCCS network also includes Federally Qualified Health Centers (FQHC), further expanding access to health care in medically underserved areas.

The acute care program integrates all covered services into a single delivery package coordinated and managed by Health Plans, with the exception of behavioral health services and specialty treatment for children with specified conditions, which are contracted under ADHS. Similarly, Program Contractors manage services for ALTCS members in the same way, except that behavioral health services are included in the single delivery system.

Under Arizona's managed care system, almost all members have a choice of at least two health plans within a GSA. Populations that do not have a choice of managed care plans include: elderly and physically disabled ALTCS members outside of Maricopa County, ALTCS members who receive services through the Division of Developmental Disabilities, and acute members who are in foster care and receiving services through the Comprehensive Medical and Dental Program. In addition, members who are eligible for services through Children's Rehabilitative Services (CRS) have a choice of MCOs for much of their care, but must receive specialty care for specified conditions through the CRS administration. All members are assured choice of service providers once enrolled in a Health Plan or Program Contractor.

AHCCCS is seeking waiver authority to allow continuation of the current model for each of these populations. Arizona is confident that the AHCCCS program meets the protections afforded by the Balanced Budget Act of 1997. These factors are discussed more thoroughly in Chapter IX. Approval of this request will allow Arizona to continue an effective managed care approach to delivering services.

## **A. Capitation Rates**

Capitation rates developed and paid to Health Plans and Program Contractors are actuarially sound. Separate capitation rates are calculated for each beneficiary group based on historic service utilization and cost experience. The rates are calculated by examining categories of services, such as inpatient acute care, outpatient services, physician reimbursement, transportation, etc., based on historic costs. Health Plans and Program Contractors may reimburse subcontractors in a number of ways as determined through the negotiation of contracts. Non-contracted providers are typically reimbursed at the AHCCCS Fee-For-Service rates or an agreed percentage of those rates. Institutional providers are required to submit annual financial and cost data to the Arizona Department of Health Services including Medicare Cost Reports and Uniform Accounting Reports. Other reports may be submitted in lieu of these reports, at the discretion of the Director. Arizona is currently in the process of modifying what is acceptable as a Uniform Accounting Report. AHCCCS monitors contractual arrangements between plans and providers. For example, timeliness of claim payments is monitored via contract and Operational and Financial Reviews, and service delivery is monitored through performance measures and quality of care processes. This demonstration seeks continued authority to maintain flexibility in arranging reimbursement agreements with health care providers.

## **B. Special Populations**

### Members Accessing Behavioral Health Services

Behavioral health services for the acute population are delivered by the Arizona Department of Health Services (ADHS) under a capitation arrangement with AHCCCS. Acute members receive behavioral health services through a network of RBHAs contracted by ADHS. Enrollment into RBHAs is based on geographic location ensuring that all members have access to one RHBA network. Each RHBA provides an established network of service providers. ALTCS members receive behavioral health services directly through the Program Contractors.

### Members who are Native American

**Acute Care:** Native Americans who utilize acute Medicaid or SCHIP benefits in Arizona have the option to select either utilization of the Indian Health Service (IHS) system or an AHCCCS Health Plan. If the member chooses IHS, all available services are provided through the IHS or a tribal facility on a FFS basis. If a covered service is not available through IHS or if IHS does not have funding to pay for the service, the member may obtain services on a FFS basis through AHCCCS. A member who has chosen IHS may change to an AHCCCS Health Plan at any time. Similarly, a member who has chosen a Health Plan can also utilize IHS services.

**Long Term Care:** Native Americans also have a choice as to how they access their long term care services. Native Americans living on reservations are enrolled with a Tribal Program Contractor or with the Native American Community Health Center (NACHC), a Phoenix-based urban Indian health provider for case management

services. Tribal ALTCS programs are paid a monthly case-management capitation rate for each ALTCS member enrolled in their respective programs. These members receive all of their services on a FFS basis.

ALTCS Native American members who live off reservation are managed by an ALTCS Program Contractor that serves the geographic service area where the member resides. IHS and tribal facilities function as the acute care providers for tribal ALTCS FFS members. These members may also receive acute care services from private sector providers on a FFS basis. The AHCCCS administration provides payment of claims, administrative oversight, technical assistance and training for tribal case managers.

#### Members with Developmental Disabilities

ALTCS services for persons with developmental disabilities are managed by the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) under a capitation arrangement with AHCCCS. DDD operates in the same manner as other Program Contractors and additionally administers a one hundred percent state-funded program for persons with developmental disabilities who not eligible for ALTCS. Once enrolled, all DDD members have a choice of managed care entities. In addition, a DDD member chooses a primary care provider who coordinates the member's care in conjunction with the member's case manager. DDD provides or contracts with individuals and agencies for services and supports for members with developmental disabilities. Services are provided to members based on the person's identified needs, and state and/or federal guidelines.

#### Members in Foster Care

Services for Arizona's children in foster care are managed by the ADES through the Comprehensive Medical and Dental Program (CMDP) under a capitation arrangement with AHCCCS. CMDP operates in the same manner as other Health Plans, except it operates an open network for members, and additionally manages the special needs of this population. Once enrolled, a CMDP member or his or her guardian, chooses a primary care provider who coordinates the member's care. CMDP provides services and support for members in the program. Once enrolled in CMDP, members have choice in selecting their service providers.

#### Members with Specified Medical Conditions

Children with certain medical, handicapping or potentially handicapping conditions receive specified services through the Children's Rehabilitative Services (CRS) program at ADHS. The program does not substitute for the role of the Health Plan or Program Contractor, but instead complements a member's acute services by providing a multi-specialty interdisciplinary team approach and a valuable specialty network. AHCCCS Health Plans and Program Contractors are required to refer children to the CRS program who are potentially eligible for CRS covered services. The AHCCCS Health Plans and Program Contractors are also required to monitor those referrals to ensure covered services are provided in a timely manner to CRS enrollees, and even with a referral to CRS, must continue to provide medically

necessary services not covered by CRS. The Health Plan or Program Contractor must also require the member's primary care provider to coordinate care with the CRS program. CRS members have choice in selecting a Health Plan or Program Contractor and in selecting their providers in both their Managed Care Organization and in the CRS program.

---

## VI. Access

Providing members with access to care has remained an AHCCCS priority since the program's inception. AHCCCS has established contractual requirements to ensure that access to care extends beyond the traditional definition of establishing eligibility and providing payment for medical care. Access to care also includes informing members about the services available to them, educating them about obtaining those services, and making services convenient, appropriate and timely. In addition, by mainstreaming members into the private sector health care network, AHCCCS has helped remove any stigmas associated with publicly funded coverage that might serve as a barrier to members seeking needed care.

### **A. Communication with Members**

AHCCCS ensures members are aware of their entitlements and the responsibilities of the program beginning with the application process, and continuing with the eligibility decision notice. Contractual provisions require Health Plans and Program Contractors (referred to in this section as Contractors) to communicate with members and provide tools to allow them to seek and receive services.

By contract, all AHCCCS Contractors are required to obtain approval from AHCCCS for all proposed marketing and information materials, and any events that will involve the general public. AHCCCS has instituted safeguards to assure that marketing is accurate and not misleading by establishing policy for allowable marketing techniques and sanctions for restricted techniques. Health Plans and Program Contractors must have signed contracts with primary care physicians (PCP), specialists, dentists, and pharmacies, in order to include them in marketing materials. Program Contractors must also have signed contracts with nursing facilities and residential placement options in order to include them in their materials. In addition, Contractors are required to report their marketing costs on a quarterly basis as a separate line item in the quarterly financial statements.

Contractors are required to be accessible by phone for general member information during normal business hours, and must provide access to a toll free phone number. They must also provide an approved member handbook and a description of the provider network to each member or family within 10 days of being notified of a member's enrollment.

Contractors must comply with federal requirements related to making oral interpretation services and written material available to members who have limited

English proficiency. All member communications must be written at a 4th grade level and printed in a type, style and size, which can easily be read by members with varying degrees of visual impairment. They must notify members of the availability of both no-cost interpreter services and alternative formats, and how to access them.

Notification must be provided to affected members at least 30 days before implementation when program changes are made.

Each Contractor is required to have a Cultural Competency Plan and an annual assessment of the effectiveness of the plan, along with any modifications.

## **B. Network**

AHCCCS contracts require each Health Plan and Program Contractor to develop and maintain a provider network that is sufficient to provide all covered services promptly and ensure that those services are reasonably accessible in terms of location and hours of operation. Medical care must be available on a 24-hour-a-day, 7-day-a-week basis. Each Contractor is expected to establish and maintain a provider network development and management plan, which is updated annually. In addition, ALTCS Program Contractors must have Case Management plans to ensure adequate staffing and compliance with AHCCCS standards for case management caseloads.

The provider network must ensure members have access to care that is at least equal to, or better than, community norms. With respect to timeliness, amount, duration and scope, the standard is that AHCCCS members be provided with accessibility comparable to non-AHCCCS persons within the same service area. Provisions are included to address issues related to covering members who may typically receive care in neighboring states or may require out-of-network coverage

AHCCCS and its Health Plans have a strong history of partnership with FQHCs and help ensure that members have continued access to them as service providers by requiring the Health Plans to have rates of payment that are not less than the amount of payment for a similar set of services with a non-FQHC.

## **C. Appointments and Referrals**

AHCCCS holds its Contractors to stringent standards regarding the availability of medical appointments for members. For example, they must have procedures in place to ensure that members are able to secure appointments with primary care providers for emergent conditions the same day of request, within 2 days for urgent issues, and within 21 days for routine health matters. Standards are also in place for specialty referrals, maternity, dental care, and non-emergent medically necessary transportation.

Contractors are required to actively monitor the adequacy of provider appointment processes and reduce the unnecessary use of alternative methods such as emergency

room visits. They must also actively monitor and ensure that a member's waiting time for a scheduled appointment at a PCP or specialist office is no more than 45 minutes, except when the provider is unavailable due to an emergency. A specific staff member or unit within each contracted organization must be assigned to monitor compliance with appointment standards. AHCCCS requires any non-compliant Health Plan to develop a corrective action plan when appointment standards are not met.

AHCCCS contracts include special provisions to ensure that members have access to specialists, including requiring Contractors to have written procedures that address the use of referral forms, seeking second opinions, and the system for resolving any disputes regarding referrals. Female members have direct access to in-network gynecology providers without a referral for preventive and routine services. For members with special health care needs determined to need a specialized course of treatment or regular care monitoring, each Contractor must have a mechanism in place to allow such members to directly access a specialist (for example through a standing referral or an approved number of visits). To ensure continuity and quality of care, Contractors must have processes in place to ensure communication and PCP follow-up of all referrals.

Out of service area specialized care may be approved by the Contractor if the care/service requested is highly specialized and not available in the member's immediate service area. Other qualified out of service area exceptions include the provision of care in neighboring states where the location of the member is so rural that this is the closest and most cost effective means of providing qualified care.

#### **D. Emergency Services**

Emergencies do not require prior authorization and the member should seek emergent care in compliance with the BBA, 42 CFR §438.114. After-hour emergencies comply with the same criteria. Monitoring occurs as follows:

- All Health Plans/Program Contractors must submit their policies to AHCCCS for review and monitoring to assure they are in compliance with the BBA standards. This is done at the time of the submission of the annual Utilization Management Plan and when changes are made
- The Health Plans/Program Contractors must submit a copy of their emergency care logs and hospital admissions to AHCCCS during the Operational and Financial Review (OFR). AHCCCS selects a random sampling (in compliance with 42 CFR 456) of cases for review to assure that all BBA guidelines are monitored, applied in accordance with emergent standards and if issues are noted, that action is taken
- Any grievance filed by a member or provider will require an individual case review, and if sustained, a potential corrective action by the Health Plans/Program Contractors or, if severe, a focused review of the Health Plans/Program Contractors and its operations.

When a member is out of the service area and emergent services are required, the Contractors cannot deny payment as set forth under the BBA emergent care standards (42 CFR 438.114). The Contractor policy on both the emergent treatment of members who are out of the service area and the plan for care post-stabilization are reviewed.

With respect to hospital services, the Contractor must allow access to care in an emergent care situation on a 24 hour/ 7 day per week basis, and cannot deny or limit access to care, even if the provider is non-contracted in an emergent situation as defined in the BBA 42 CFR 438.114.

---

## VII. Quality

Even prior to the federal government establishing quality management requirements under the Balanced Budget Act of 1997 (BBA), Arizona had developed and implemented a comprehensive quality management process through this demonstration. Ensuring quality of care for AHCCCS members is a common goal for both AHCCCS and the Health Plans and Program Contractors (referred to in this section as Contractors). AHCCCS ensures that each Contractor has an ongoing quality assessment and performance improvement program for the services it furnishes to members, consistent with regulations under the BBA.

### **A. Providers**

All providers must be registered with AHCCCS to provide services to AHCCCS members. To become an AHCCCS registered provider, practitioners must submit documentation of their educational degree, license, DEA license and malpractice insurance, and not be restricted from participating in federal programs. In addition, providers must meet minimum credentialing standards, similar to the National Committee for Quality Assurance (NCQA) credentialing standards, as required in the AHCCCS Medical Policy Manual and as implemented by AHCCCS Contractors. AHCCCS Contractors cannot discriminate against providers serving high-risk populations or specializing in conditions that require costly treatment. AHCCCS requires plans to: provide adequate access to providers; routinely provide data documenting a plan's stability and levels of care provided; and conduct various studies, performance measures and performance improvement projects that measure patient outcomes.

### **B. Quality Management**

In 1995, AHCCCS, with the support of CMS, initiated the Quality Management system designed to measure health care outcomes within a managed care quality environment. This Quality Management system predates the BBA and has been incorporated and updated into the AHCCCS Quality Strategy to remain fully compliant with the BBA. The Quality Strategy is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. It is designed to identify and document issues related to those standards, and encourage improvement through incentives, or corrective actions where necessary. AHCCCS regularly submits acute and long term care utilization, performance measures, performance improvement projects, and quality improvement reports to CMS, and also conducts and publishes member satisfaction and provider satisfaction surveys.

The following are encompassed within the scope of the Quality Strategy:

- Medicaid and SCHIP managed care members in the acute, long term care, Children's Rehabilitative Services and behavioral health programs.
- Aspects of care including: coordination, accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by AHCCCS.
- Aspects of Contractor performance relating to access to care, quality of care and service including, but not limited to: disease management, preventative care, health promotion, patient care planning, network contracting and credentialing, and grievance systems.
- Medically necessary covered services such as inpatient hospital services, outpatient services, other laboratory and x-ray services, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, behavioral health services, physician services, home health services and emergency services.
- Professional and institutional care in any setting, including inpatient and outpatient, in-home, and alternative settings.
- Providers and any other delegated or subcontracted provider type such as providers of transportation and durable medical equipment.
- Aspects of the Contractors' internal administrative processes that are related to service and quality of care. This includes member services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information systems and quality management/improvement.

AHCCCS Contractors are required to execute processes to assess, plan, implement and evaluate quality management and performance improvement activities that include: conducting Performance Improvement Projects (PIPs); Quality Management monitoring and evaluation activities; investigation, analysis, tracking and trending of quality of care issues, abuse, neglect and/or complaints; AHCCCS mandated performance indicators; and credentialing and recredentialing processes. AHCCCS Contractors have been pivotal partners in improving quality in a managed care environment. Independently, many of the Contractors have exceeded AHCCCS' requirements in order to improve health outcomes through their own continuous quality improvement programs.

AHCCCS follows the NCQA guidelines but has added a few additional requirements for the re-credentialing process. For re-credentialing, AHCCCS requires Contractors to review and incorporate quality of care concerns and trends, and profile information. AHCCCS has also implemented a provisional credentialing process for providers based in Federally Qualified Health Care Centers and other needed provider types, which allows them to start seeing AHCCCS members within 14 days of their completed application, license, DEA license and malpractice insurance being received by the Contractor. AHCCCS requires an on-site review of medical practices

by Contractors during the contracting process. Additionally, Contractors are required to conduct medical chart reviews as part of the re-credentialing process for primary care physicians and high volume specialists. Patient and provider demographic, clinical, and financial data including coordination of benefits is collected for all AHCCCS covered services.

AHCCCS also implemented the HEDIS rotation schedule for the following Performance Measures:

- Well Child Visits 0-15 Months
- Well Child Visits 3-6 Years of Age
- Adolescent Well Care Visits
- Adolescent Immunizations
- Childhood Immunizations
- Oral Health
- Cervical Cancer Screening
- Breast Cancer Screening
- Timeliness of Prenatal Care
- Adults Access to Ambulatory Care
- Children's Access to Care

A Contractor that has not shown demonstrable and sustained improvement toward meeting AHCCCS Performance Standards is required to submit a corrective action plan, and failure to achieve adequate improvement may result in sanctions.

AHCCCS policies allow the State to implement annual Performance Improvement Project topics. The following Performance Improvement Projects have been implemented:

- Diabetes (based on the HEDIS criteria) (ALTCS and Acute)
- Oral Health (ALTCS and Acute)
- Childhood Immunizations (Acute)
- Care Coordination of members with Comorbid Diseases (ALTCS)
- Increase Reporting of Immunizations to State Registry

## **C. Grievances and Appeals**

Each Managed Care Organization (MCO) and Prepaid Inpatient Health Plan (PIHP) is required to maintain a grievance system for members, including a grievance process, an appeals process and access to the State's fair hearing process. All Contractors must comply with the requirements delineated in 42 CFR 438.400 et seq., state regulations A.A.C. R9-34-201 et seq., the grievance system standards specified in the AHCCCS-MCO/PIHP contract, and the provisions described in the AHCCCS Contractor Operations Manual. Contractors must ensure they retain appropriate personnel to establish, implement and maintain the necessary functions related to the grievance system process. Furthermore, each Contractor must have a written grievance system process which defines member rights with respect to disputed matters.

Contractors are required to timely provide written information to members clearly explaining the grievance system requirements. This information must meet limited English proficiency and cultural competency requirements. Included in the information provided to members are the following: a description of the right to a fair hearing; the method for obtaining a state fair hearing; the rules that govern representation at the hearing; the right to file grievances and appeals; the requirements for filing grievances and appeals; the availability of assistance in the filing process; the toll free telephone numbers that can be used to file grievances or appeals; a statement that benefits will continue when requested by the member when the appeal is timely filed, that the member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the member, and that a provider may file an appeal on behalf of a member with the member's written consent.

Grievances which pertain to quality of care issues are referred to the quality management process for review, resolution, and follow-up. The quality management process maintained by each Contractor must also comply with all federal and state requirements. The AHCCCS quality of care resolution process requirements are clearly defined in the AHCCCS Medical Policy Manual (AMPM). As a part of the Contractor's process for reviewing and evaluating member and provider issues, there must be written policies and procedures, initial and ongoing processing of these concerns that include documenting each issue raised, when and from whom it was received, and the projected time frame for resolution.

Contractors are required to assist the member or provider as needed in completing forms or taking other necessary steps to obtain resolution of the issue and inform the member or provider of all applicable mechanisms for resolving the issue external to the Contractor processes. Contractors are required to acknowledge receipt of the issue to the member, provide assistance to ensure immediate health care needs are met, assess the level of severity of the quality of care issue, communicate the resolution of the concern to the member, implement appropriate corrective actions, monitor the corrective actions for effectiveness, and incorporate improvements into the quality management program if successful.

All quality of care concerns are tracked and trended and AHCCCS and/or Contractors may utilize this information to make improvement to care and services. Contractors are required to submit quarterly quality management reports to AHCCCS to allow for tracking and trending of issues at the AHCCCS Program level. In addition, if a trend is identified, AHCCCS may select it as an area to implement as a system-wide performance improvement project (PIP). The AHCCCS Administration, through its oversight responsibilities, also maintains a rigorous quality management process, similar to the process described above, which also evaluates the quality and delivery of care to enrolled members.

Both the Grievance System Process and the Quality Management Process of each Contractor are reviewed annually by the AHCCCS Administration through its comprehensive Operational and Financial Reviews. Moreover, Contractor deficiencies identified through the grievance system process, including the state fair hearing process, are evaluated and referred for corrective action when appropriate.

---

## VIII. Finance

Financial materials to be submitted at a later date

---

## IX. Waiver and Expenditure Authority Requested

In order for Arizona to continue its cost effective and successful managed care model as described in this proposal, the state requires continuation of current waivers from certain statutory requirements of the Social Security Act, as authorized under §1115(a)(1) of the Act. AHCCCS also requests continuation of federal financial participation for certain costs not otherwise matched, as authorized under §1115(a)(2) of the Act. AHCCCS also requests approval for new authorities in this demonstration. These new authorities include Employer Sponsored Insurance, and reimbursement for spouses of ALTCS members to serve as caregivers. Additionally, AHCCCS seeks clarification of existing waiver and expenditure authority to ensure that Arizona can continue to build on the solid history achieved by the current model of managed care.

### A. Waivers Requested for Continuation

AHCCCS is requesting renewal of all current necessary waiver authority to continue operating its demonstration:

- Cost Sharing- Consistent with §1916(b) and 42 CFR 447.56, to enable the State to impose twice the nominal amount of cost sharing on all eligible persons for non-emergency use of the emergency room. §1902(a).
- Freedom of Choice- To enable the State to restrict freedom of choice of provider to the providers in the network of the MCO or PIHP with whom the eligible person is enrolled. Among other things, this waiver will allow the State to restrict the freedom of choice upon re-enrollment for individuals who lose eligibility and then become eligible again within 90 days. §1902(a)(23) and 42 CFR 431.51.
- Capitation/Upper Limits- To enable the State to obtain flexibility in arranging reimbursement agreements with health care providers. §1902(a)(13) and 42 CFR 447.250 – 447.371 (except for the public notice provisions in §1902(a)(13)(A)).
- 30 days in Hospital- To enable the State to exclude hospitalized individuals and others not requiring long term care (LTC) services from the optional

institutionalized eligibility categories. §1902(a)(10)(A)(ii)(V) and 42 CFR 435.217 and 435.236.

- Drug Rebate- To enable the State to receive payments for outpatient drugs without complying with the requirements of the Omnibus Budget Reconciliation Act of 1990 pertaining to drug rebate and drug use review. §1902(a)(54) and 42 CFR 456.700 – 456.725.
- Disregards- To enable the State to disregard quarterly income totaling less than \$20 from the post eligibility determination. §1902(a)(17), §1902(a)(51), and 42 CFR 435.725 and 435.726.
- Different Benefits- To the extent necessary to permit the State to offer different benefits to managed care organization enrollees that are not offered to Medicaid beneficiaries not enrolled. §1902(a)(10)(B)(i) and 42 CFR 440.240.
- Prior Quarter- To enable the State to waive the requirement to provide medical assistance for up to three months prior to the date that an application for assistance made. §1902(a)(34) and 42 CFR 435.914.
- Estate Recovery- To enable the State to exempt from recovery the estate of acute care enrollees age 55 or older who receive LTC services to the extent it requires compliance with §1917(b) and 42 CFR 433.36(h). §1902(a)(18).

## **B. Expenditure Authority Requested for Continuation**

Under the authority of §1115(a)(2) of the Act, expenditures made by the State for the items identified below (which would not otherwise be included as matchable expenditures under §1903) shall, for the period of this project, be regarded as matchable expenditures under the State's Medicaid State Plan:

- Expenditures for hospital services that would not otherwise be federally matchable due to the limits on matching §1903(i)(3).
- Expenditures under contracts with managed care entities that do not meet the requirements in §1903(m)(2)(A) specified below. AHCCCS' managed care plans participating in the demonstration will have to meet all requirements of §1903(m) except the following:
  - §1903(m)(2)(A)(i), but only insofar as the provisions of §1903(m)(1)(A)(i) would otherwise preclude Native Americans from having a choice to enroll in either the IHS facilities or AHCCCS plans;
  - §1903(m)(2)(A)(vi) insofar as it requires compliance with the requirement of §1932(a)(4)(A)(ii) that individuals be permitted to terminate or change enrollment without cause during the first 90 days of enrollment.

Expenditure authority is sought notwithstanding the regulation implementing this requirement – 42 CFR 438.56(c)(2)(i).

- §1903(m)(2)(A)(viii) and §1903(m)(4)(A) and (B), but only insofar as these provisions relate to disclosure of transactions between AHCCCS plans and parties in interest.
- Expenditures associated with the provisions of home and community-based services (HCBS) to individuals determined to be eligible and for services specified in the program. Those expenditures include, but are not limited to, the establishment of ALTCS eligibility for all individuals with income levels up to 300% of the SSI Federal Benefit Rate, whether institutionalized or non-institutionalized, as well as individuals enrolled in the ALTCS Transitional program; waiving parental income for children up to age 18; and imposing the share of cost and personal needs allowance requirements.
- Expenditures for outpatient drugs which would otherwise be excluded by virtue of §1903(i)(10).
- Expenditures to extend ALTCS eligibility to individuals under 65 using the Preadmission Screening instrument as a substitute disability standard.
- Expenditures to provide continued medical coverage to children who meet the initial eligibility requirement as a deemed newborn without consideration of the mother's continued Medicaid eligibility.
- Expenditures to provide family planning services for up to 24 months to AHCCCS eligible women who subsequently lose eligibility at 60 days post-partum.
- Expenditure for services to AHCCCS enrollee age 21-64 residing in an Institution for Mental Diseases (IMD) for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days.
- In determining the eligibility of ALTCS applicants and recipients, expenditures associated with excluding from the 300% of SSI Federal Benefit Rate test and post-eligibility calculations the income currently excluded from the 100% of SSI Federal Benefit Rate test listed in §1612(b) of the Act.
- Expenditures associated with eliminating the 30-day wait for use of 300% of SSI Federal Benefit Rate as the income limit in determining eligibility for new ALTCS applicants.
- Expenditures associated with allowing some dependent children or spouses to qualify for ALTCS one month earlier than usual by disregarding the income and resources of responsible relatives or spouses in the month of separation.

- Expenditures associated with disregarding in-kind support and maintenance (ISM) as income in determining eligibility for QMB, SLMB, QI-1, or SSI-MAO benefits.
- Expenditures associated with changing the budget process for ALTCS and SSI-MAO income eligibility determinations when there is an eligible or ineligible spouse (if the spousal impoverishment requirements of §1924(b) of the Act do not apply) or when the applicant/recipient is living with a minor dependent child.
- Expenditures associated with simplifying the life insurance and burial funds policy in the eligibility determination process for the SSI-MAO groups.
- Expenditures associated with excluding the value of household goods and personal effects in the eligibility determination process for SSI-MAO groups.
- Expenditures associated with excluding the value of mineral rights, oil rights and timber rights in the eligibility determination process for SSI-MAO groups.
- Expenditures associated with allowing resource determinations to be made based on verification produced for any date during a calendar month, making the individual eligible for the entire month.
- Expenditures to provide Medicaid coverage to individuals with adjusted net countable income at or below 100% of the FPL who are not otherwise eligible for Medicaid.
- Expenditures to provide Medicaid coverage to individuals who have medical bills incurred by the family unit sufficient to reduce their adjusted net countable family income to 40% or less of the FPL, and who are not otherwise eligible for Medicaid.
- Expenditures that would have been disallowed under §1903(u) of the Act based on MEQC findings.
- Expenditures for medical assistance provided to individuals who are determined to be eligible for Medicaid as SSI recipients under the “Pickle Amendment,” §503 of Public Law Number 94-566; §1634(c) of the Act (disabled adult children); and §1634(b) of the Act (disabled widows and widowers), who because of excess resources actually do not qualify for this status.

Under the authority of §1115(a)(2) of the Act, as incorporated into Title XXI by §2107(e)(2)(A), State expenditures described below (which would not otherwise be included as matchable expenditures under Title XXI) shall, for the period of this

project and to the extent of the State's available allotment under §2104 of the Act, be regarded as matchable expenditures under the State's Title XXI Plan:

- Expenditures to provide Medicaid coverage to individuals over 18 with an adjusted net countable family between 40% and 100% of the FPL, who are single adults and childless couples, and who are not otherwise eligible for such coverage, except through the demonstration project amendment approved January 18, 2001.
- Expenditures to provide demonstration coverage consistent with the requirements of §2103 to individuals whose adjusted net countable family income exceeds 100% FPL, but does not exceed 200% FPL, who are parents of children enrolled in the Arizona Medicaid or Title XXI programs, and who are not otherwise eligible for Medicaid or Title XXI coverage.

### **C. Proposals previously submitted pending CMS approval**

- ALTCS Cost Sharing- Waiver and expenditure authority to impose a monthly premium on all households with adjusted gross income at or above 400% of the FPL that have children under the age of 18 with developmental disabilities enrolled in ALTCS. The original ALTCS Premium proposal is attached in Appendix V.

The Arizona Center for Disability Law (the Center) has provided AHCCCS with comments regarding various issues raised by this renewal proposal. While not all comments are included in this document, AHCCCS finds it prudent to communicate the legal issues raised by the Center regarding the ALTCS cost sharing proposal. Among several arguments, the Center notes that the statute passed by the Arizona Legislature, as well as the waiver requested by AHCCCS to implement this legislation, is suspect because it treats children enrolled with the DD/ALTCS program differently from those children enrolled with the Elderly and Physically Disabled (EPD) program of ALTCS. The Center advises that such a distinction may run afoul of both the Americans with Disabilities Act and the Rehabilitation Act and subject the state, and CMS, to possible litigation. The Center also states that implementation of the proposal may result in violations of state law and other provisions of federal law included in the Medicaid Act.

- Disregard of Interest- Expenditure authority to disregard interest and dividend income from excluded resources under §1613(a) of the Social Security Act for determining Arizona Long Term Care System (ALTCS) and SSI-MAO eligibility. The Disregard of Interest original proposal is attached in Appendix VI.

### **D. New Waiver/Expenditure Authority Requested**

In addition, AHCCCS is requesting approval of the following:

- Employer Sponsored Insurance- Waiver authority to implement an Employer Sponsored Insurance (ESI) program. The ESI program would allow the state to provide premium subsidies for the purchase of employer sponsored health insurance for eligible individuals. This program would be available statewide to employees who work for businesses with no more than 25 employees. The ESI proposal is provided in Appendix VII.
- Spouses as Paid Caregivers- AHCCCS requests authority to implement a voluntary program for spouses as paid caregivers. The purpose of the program is to provide reimbursement to spouses of eligible Medicaid members who require long term care, so the members can remain in their own home, contributing to quality of life for the member while also creating savings for the program by reducing higher costs associated with institutionalization. AHCCCS is requesting waiver authority pursuant to the authority of §1115(a)(1) of the Social Security Act related to the following sections:
  - § 1902(a)(10)(B)- to permit the state to offer Demonstration participants benefits that are not equal in amount, duration, and scope to those offered to other Medicaid beneficiaries.
  - §1902(a)(27)- to permit the provision of care by individuals who have not executed a Provider Agreement with the State Medicaid Agency.
  - §1902(a)(32)- to permit payments to be made directly or indirectly to beneficiaries or their representatives.

As part of the program, AHCCCS will monitor aggregate costs for participants to ensure that costs are not significantly higher than they would be in the absence of the pilot. Therefore, §1115(a)(2) authority of the Social Security Act is requested, for the following expenditures to be made by the State under the demonstration (which are not otherwise included as expenditures under §1903) for the period of the demonstration to be regarded as expenditures under the State's Title XIX plan:

- Expenditures for Demonstration caregiver services provided by spouses of the Demonstration participants
- Expenditures to provide services that are not covered under the State Plan as Demonstration services.

## **E. Clarification of Existing Waiver/Expenditure Authority**

In addition to the new initiatives being sought above, AHCCCS intends to operate the same cost effective managed care approach to deliver services to members. CMS has informed the State that additional authority is required in order to sustain the current Arizona model. Each of the following requests is related to the Balanced Budget Act

of 1997 (BBA) and is sought to allow the continued success of Arizona's Medicaid program.

- Medicaid Managed Care Requirements- Expenditure authority related to §1903(m)(2) which requires a state to enforce certain requirements of §1903(m) under contracts with managed care entities for the following:
  - Choice of Coverage - § 1903(m)(2)(A)(xii) insofar as it requires compliance with the requirements of § 1932(a)(3) that individuals be afforded a choice of not less than two Managed Care Organizations. Expenditure authority is sought notwithstanding the regulation implementing this requirement – 42 CFR 438.52. Pursuant to this waiver, AHCCCS will:
    - Offer all eligible persons enrolled in the acute care program a choice of at least two managed care entities, with the following exceptions:
      - All eligible persons enrolled in the acute care program will receive behavioral health services through the Arizona Department of Health Services Division of Behavioral Health Services acting as a Pre-paid Inpatient Health Plan;
      - Children placed in a foster home and children in the custody of the Arizona Department of Economic Security and placed with a relative, in a certified adoptive home, or an independent living program will receive acute care services through the Arizona Department of Economic Security Comprehensive Medical and Dental Program acting as a Managed Care Organization;
      - Children receiving services through a grant under section 501(a)(1)(D) of Title V of the Social Security Act will receive treatment for the child's qualifying condition (as defined in State law) through the Arizona Department of Health Services Children's Rehabilitative Service Program acting as a Pre-paid Inpatient Health Plan; and
    - Offer persons eligible for long term care services and residing in Maricopa County a choice of at least two Managed Care Organizations with the following exception:
      - Children with Developmental Disabilities will be enrolled with the Arizona Department of Economic Security Developmental Disabilities Division acting as a Managed Care Organization.
  - Disenrollment with Cause - § 1903(m)(2)(A)(vi) insofar as it requires compliance with the requirement of § 1932(a)(4)(A)(i) that individuals

be permitted to terminate or change enrollment for cause at any time to the extent that the regulation implementing this requirement – 42 CFR 438.50(c)(1) – defines cause. Notwithstanding this waiver, AHCCCS will permit individuals to change enrollment to ensure continuity of care. Expenditure authority is sought notwithstanding the regulation implementing this definition – 42 CFR 438.50(c)(1).

- Limitations on Automatic Re-enrollment - § 1903(m)(2)(H)(ii) to the extent necessary to permit AHCCCS to require automatic re-enrollment in a previous managed care entity when the individual is not eligible for the next three (3) months (rather than 2 months as provided in statute). Expenditure authority is sought notwithstanding the regulation implementing this limitation – 42 CFR 438.56(g).

## **F. Background Information for Existing Waiver/Expenditure Authority Clarification Issues**

### **●Choice of Coverage**

While the BBA specifies that Medicaid enrollees must have a choice of two or more Managed Care Organizations (MCOs) operating in Metropolitan Statistical Areas (MSAs), there are several instances where the Arizona model currently ensures the availability of only one MCO. In each of these situations, it is important to recognize that all acute members, no matter which Health Plan they are enrolled in, have access to the same benefit package. The same is true for ALTCS members. In addition, all Health Plans and Program Contractors are equally monitored and regulated with respect to access to care and quality of care. AHCCCS ensures that all members receive quality service and care whether or not a member is able to choose between MCOs.

The following members have one MCO available to them:

#### ALTCS Members Outside of Maricopa County

AHCCCS contracts with one Program Contractor for each Geographical Service Area outside of Maricopa County. Once enrolled in a Program Contractor, members have a choice of primary care physicians, case managers, and other providers.

The requirement of two MCOs is particularly problematic for the Elderly and Physically Disabled (EPD) ALTCS population. ALTCS is a statewide program with a total of only 24,611 EPD members. A primary reason that only one MCO is available in areas outside of Maricopa County involves the small number of members in many of the large rural areas of the state. Requiring two Program Contractors to divide the small membership in these expansive sparsely populated areas is difficult because of the need to develop an adequate network of care, as well as the need to manage costs

without the usual economies of scale available to assist with prudent purchasing. In some of these areas, Medicaid is the only consistent payor source. The establishment of just one Program Contractor in these areas allows for the best development of a network for higher cost specialty settings and services. It also is important to recognize that in some of the rural areas, Medicaid is essentially the only payor for long term care services. In these instances, choice of program contractor would not enhance choice of provider.

In addition, this issue requires discussion of some of the strengths that have developed as a result of this model. In counties outside of Maricopa, the Program Contractors have developed unmatched expertise in understanding the needs of members. They manage with a strong focus on local services and resources. They know their membership and the communities they serve. This is a benefit that members rely on and that contributes to a consumer-centered approach to management of services.

Another important consideration is that each ALTCS member has the ability to select a case manager. The case managers work to ensure that the member has access to needed services. AHCCCS establishes a minimum ratio of case managers and conducts annual reviews of case management services including reviews of decisions made and member feedback.

In addition, the reimbursement method that AHCCCS developed is designed to create an incentive for good healthcare management by the Program Contractor. The reimbursement method offers a strong incentive for the provision of Home and Community Based Services. Considering the significant disincentive that Program Contractors have to allow the health of members to deteriorate to the point of requiring care in a nursing facility, it is in the best interest of the Program Contractors to provide all needed services.

#### Acute Members Accessing Behavioral Health Services

Behavioral health services for the acute population are delivered by the Arizona Department of Health Services (ADHS) under a capitation arrangement with AHCCCS. Acute members receive behavioral health services through a network of RBHAs contracted by ADHS. All acute members have access to one RHBA network. Once enrolled in a RHBA, members may then select providers based on the established network. A strength of the program is the coordination of care it achieves, as well as its cost-effectiveness. It also allows for the use of non-Title XIX money to be spent in coordination with Title XIX funds for Title XIX members. Like many other states, Arizona has found that this managed care model of providing behavioral health services is beneficial both to the members and to the program overall.

### Members with Developmental Disabilities

AHCCCS contracts with one Program Contractor for ALTCS members with developmental disabilities. The Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) manages Medicaid and non-Medicaid services for this population. DDD currently subcontracts with four Managed Care Organizations to deliver acute care services to AHCCCS members. Once enrolled with DDD, members are provided with a choice of MCOs in every county. Members also have a choice of primary care physicians, case managers, and other providers.

A strength of this model is that it allows for a tailored network that is designed to specifically meet the needs of members with developmental disabilities. In addition, case managers have the training and experience necessary to effectively serve the special needs of this population. The model also allows for the use of non-Title XIX money to be spent in coordination with Title XIX funds for Title XIX members.

### Members in Foster Care

Under a capitation arrangement with AHCCCS, ADES manages services for Arizona's children in foster care through the Comprehensive Medical and Dental Program (CMDP). CMDP provides services and supports for members in the program. Once enrolled, a CMDP member has unrestricted choice of a registered primary care provider who coordinates the member's care. CMDP Arizona has created a comprehensive system with specialized expertise in coordinating the unique health care needs of children in the foster care system. CMDP is best equipped to manage the cross-system challenges confronted by children in the foster care system, including those related to mental health, child welfare, and health systems. CMDP also helps to ensure access and continuity of care, especially when children change placements.

A strength of this model is that it allows for staffing that recognizes the unique needs of this population. The CMDP works to ensure that other complications that foster children may experience, such as judicial interaction, will not be a barrier to access to quality care.

### Members with Specified Medical Conditions

Children with certain medical, handicapping or potentially handicapping conditions receive specified services through the Children's Rehabilitative Services (CRS) program at ADHS. The program does not substitute the role of the Health Plan or Program Contractor, but instead complements a member's acute Health Plan or Program Contractor by providing a multi-specialty interdisciplinary team approach and a valuable specialty network.

The rationale behind this model is that the needs of the members are better met by a system that specializes in dealing with these serious conditions.

The provider network is clearly tailored to meet the needs of this population, as is the CRS administration.

#### **•Disenrollment and Reenrollment**

The current AHCCCS policy regarding disenrollment prohibits members from disenrolling from an MCO for no cause within the first 90 days of enrollment. Arizona currently has a waiver that allows this policy to be implemented and is seeking renewal of this waiver. AHCCCS policy also prohibits members from disenrolling from an MCO at any time other than to ensure continuity of care for the member or at annual open enrollment. In addition, when a member has left the program and returns within 90 days, AHCCCS automatically re-enrolls the member into the same plan that he or she was enrolled in when disenrollment occurred.

The policies described above have developed over the years as part of the distinct managed care model that Arizona operates. In the absence of the current disenrollment and reenrollment policies, the potential for abuse of the system increases. Specifically, there would be great opportunity for manipulation of the policies to facilitate frequent change of plans. AHCCCS is particularly concerned about AHCCCS members whose actions could be motivated by substance abuse or mental illness. The policy that AHCCCS has implemented allows for disenrollment when critical to continuity of care. For example, AHCCCS has worked with members who are in situations involving high risk pregnancies, or who have other complicated conditions that require consistent care from physicians such as oncologists. In situations such as these, AHCCCS will work with the member to ensure continuity of care.

AHCCCS has consistently worked to develop safeguards to ensure that existing disenrollment policies do not result in situations where a member's needs are being unmet. It is a result of these measures that less than 3% of acute care members choose to change plans at open enrollment each year. The program is designed to ensure that all members have quality care available to them no matter which Health Plan or Program Contractor they are enrolled with. These safeguards are further described in the following section.

#### **•The Arizona Model Values Member Protections**

With respect to the choice of coverage issues, as well as the disenrollment issues, it is important to note that AHCCCS currently complies with requirements under the BBA.

- AHCCCS members are able to choose from at least two physicians. ALTCS members have choice in selecting physicians, and also have choice regarding case managers.

- Health Plans and Program Contractors are required to develop a network plan, including a specialty network that includes an evaluation of

membership, determination of service needs, and implementation of a plan that meets those needs. In cases where AHCCCS identifies that a network plan is insufficient to meet the needs of members, corrective action is required.

- AHCCCS requires Health Plans and Program Contractors to monitor appointment availability and has specific standards that Health Plans and Program Contractors must adhere to.

- If a Health Plan or Program Contractor does not, because of moral or religious objections, provide a coverable service a member seeks, that Health Plan or Program Contractor is required to arrange for the provision of such service in conjunction with the State.

- If a member's primary care provider or other provider determines that a member needs related services that would subject the member to unnecessary risk if received separately and not all of the related services are available within the network, the Health Plan or Program Contractor is required to provide or arrange for the provision of the services.

- Finally, if the Health Plan or Program Contractor determines that other circumstances warrant out-of-network treatment, the Administration retains discretion to authorize such treatment.

In addition to those listed above, AHCCCS contracts contain numerous instances of policies and standards in place to assure quality and access to service. The AHCCCS Medical Policy Manual requires contractors to ensure access, availability and coordination of care, as well as quality of care to members.

Finally, the Quality of Care procedures are also protections to ensure that a restriction of choice does not result in a restriction of services. AHCCCS takes every quality of care concern seriously, and maintains a vigorous quality management process. The AHCCCS Administration, as well as each Health Plan and Program Contractor must have a formal system of managing and monitoring quality of care concerns. Whether a quality of care issue is reported to the Administration or to the Health Plan or Program Contractor, the following requirements apply to the treatment of the concern:

- All quality of care concerns are acknowledged in writing to the member,
- Assistance must be provided to ensure that the immediate health care needs of the member are met,
- Each individual issue raised in a quality of care complaint is investigated and action is taken as necessary on each issue,

- The member must be informed of the resolution, and the concern must be monitored to evaluate the effectiveness of any corrective actions involved,
- All quality of care concerns must be tracked and trended, and AHCCCS requires systemic interventions as necessary,
- In addition, deficiencies identified through the grievance process, including the state fair hearing process, are evaluated and referred for corrective action when appropriate.

In requesting the waiver authorities described in this document, Arizona has described the strong member protections that exist throughout the program. The protections highlighted in this document exist to ensure that even when members are mandated into managed care and are provided no choice as to managed care entities, the standards in place for those managed care entities result in care that is of the highest quality. It can be surmised that the purpose of allowing choice is to allow members to leave substandard care for better care. Typical reasons for dissatisfaction include insufficient provider network, poor medical management, substandard benefit coverage, and quality management. In each of these areas, AHCCCS has placed rigorous standards on its Health Plans, Program Contractors, and Prepaid Inpatient Health Plans. Due to these stringent requirements, all managed care entities must perform at the same high level or they will face a corrective action plan or sanctions. The AHCCCS administration goes to great length to ensure that all managed care entities perform at this same high level. In doing so, AHCCCS ensures that Arizona has member protections in place that meet or exceed the requirements of the Balanced Budget Act of 1997.

---

# X. Operational Protocols

## OPERATIONAL PROTOCOLS FOR ARIZONA TABLE OF CONTENTS

I.	BUDGET NEUTRALITY.....	41
	Financial Reporting	
	100% FPL Expansion	
	Reporting of Direct Medical Services Expenditures	
	Administrative Expenditures	
	Member Month Reporting	
	Monitoring Budget Neutrality	
	Statistical Reporting	
II.	HIFA.....	46
	Background	
	Employer Sponsored Insurance Pilot Program	
	Financial Requirements	
	Expenditures for Direct Medical Services	
	Budgeted Expenditures	
III.	REIMBURSEMENT FOR CRITICAL ACCESS HOSPITALS.....	50
	Reimbursement for Critical Access Hospitals	
IV.	AHCCCS DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.....	51
	Background	
	Qualifying Criteria	
	Disproportionate Share Payments	
	OBRA 93 Payment Limits	
V.	COST SHARING.....	56
	Background	
	Co-payments	
	Premiums	
	Populations Exempt from Premiums	
	Enrollment Fees	
	Grievance and Appeals	
	Public Involvement	

## **I. BUDGET NEUTRALITY**

### **Financial Reporting**

The following financial reporting operational protocol, in compliance with the 1115 Waiver, Special Terms and Conditions, Attachment A, Item 4, includes the financial reporting requirements of Attachment D, and is provided as a tool to document our mutual understanding of the financial reporting requirements.

### **100% Federal Poverty Level (FPL) Expansion**

The financial reporting and claiming of federal financial participation (FFP) is designed to comply with the following reporting objectives:

- Report separately, the acute care program expenditures subject to the budget neutrality agreement and all other expenditures not subject to the budget neutrality agreement.
- Track and monitor the variance between the actual FFP expenditures subject to the budget neutrality agreement and the periodic FFP expenditure targets within the five and one-half year FFP budget neutrality period.
- Monitor the variance between the cumulative FFP subject to the budget neutrality agreement and the cumulative FFP budget neutrality funding limitation.
- Report expenditures separately for the populations subject to the budget neutrality agreement, AFDC/SOBRA, SSI and the 100% of FPL expansion for childless couples and the Medical Expense Deduction (MED) Program, from expenditures not subject to the budget neutrality agreement.
- Report, in the narrative section of the CMS-37 Medicaid Program Budget Report, an estimate of expenditures for the components of the acute care program subject to the budget neutrality agreement.
- Report separately, using a cost allocation method developed by AHCCCS and reviewed by CMS, the administrative costs of:
  - 1) The acute care program excluding the Medicaid in Public Schools (MIPS) program, the Freedom to Work program and the Breast and Cervical Cancer Treatment program.
  - 2) All other programs including the Arizona Long Term Care System (ALTCS), the MIPS program, the Freedom to Work program and the Breast and Cervical Cancer Treatment program.

AHCCCS started tracking expenditures against the periodic expenditure targets and the five and one-half year cap on April 1, 2001. Due to the April 1 date, the "first demonstration year" for budget neutrality purposes is from April 1, 2001 through September 30, 2002. Subsequent demonstration years begin October 1 and end September 30.

Expenditures subject to the budget neutrality cap include all Federal Medicaid expenditures. These include capitation, fee-for-service, reinsurance, Medicare premiums, graduate medical education, and disproportionate share hospital (DSH) payments, including expenditures for the base population and the expansion population. Expenditures excluded from the budget neutrality

cap are the MIPS program, Breast and Cervical Cancer Treatment program expenditures, Freedom to Work program expenditures, ALTCS expenditures, and all administrative expenditures.

### **Reporting of Direct Medical Services Expenditures**

All claims related to the budget neutrality agreement are reported as a part of the state's quarterly CMS-64 expenditure report via the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES). Non-waiver expenditures are reported on Forms CMS-64.9 and CMS-64.9P and require no unique naming or numbering conventions. Waiver expenditures are reported on the Forms CMS-64.9 WAIV and CMS-64.9P WAIV and require unique naming and numbering conventions. The CMS-64 forms, form names, waiver numbers and demonstration years are defined in the following two tables:

CMS Form	Waiver Name	Waiver Type	Waiver Number and Extension**
64.9 WAIV	AFDC/SOBRA	1115	11W00032/9-**
64.9 WAIV	SSI	1115	11W00032/9-**
64.9 WAIV	AC/MED	1115	11W00032/9-**
64.9P WAIV	AFDC/SOBRA	1115	11W00032/9-**
64.9P WAIV	SSI	1115	11W00032/9-**
64.9P WAIV	AC/MED	1115	11W00032/9-**

**Waiver Number Extension	Demonstration Year
01	April 1, 2001 – September 30, 2002
02	October 1, 2002 – September 30, 2003
03	October 1, 2003 – September 30, 2004
04	October 1, 2004 – September 30, 2005
05	October 1, 2005 – September 30, 2006

The tenth character of “9” in the waiver number designates CMS Region IX. The last two characters of the waiver number, referred to as the waiver number extension, are utilized by MBES/CBES to track expenditures by demonstration year, the year in which services were rendered or the period for which capitation payments are made.

Fee-for-Service (FFS) expenditures paid during the quarter ended September 30, 2003 are sorted by date of service and assigned to the demonstration year 11W00032/9-02 or 11W00032/9-01 on the current quarter expenditure report for the quarter ending September 30, 2003. Capitation payments made in the quarter ended September 30, 2003 for services covered in October 2003 will be claimed on the current quarter expenditure report for the quarter ending September 30, 2003, but will be assigned to the next demonstration year 11W00032/9-03.

Tracking of expenditures against the annual expenditure targets and the five and one-half year cap began April 1, 2001. The expenditure reporting and waiver naming and numbering convention enables AHCCCS and CMS to compile the Section 1115 Demonstration Waiver

expenditures within each waiver year in compliance with the expenditure cap requirements of the Special Terms and Conditions Attachment C, Item 7. In MBES, the expenditures for each demonstration year automatically accumulate on the CMS-64 Waiver Expenditure Report - Schedule C.

All offsetting adjustments attributable to the budget neutrality agreement normally reported on lines 9 or 10-C of the forms CMS-64.9 and CMS-64.9P are reported on line 10-B of the forms CMS-64.9 WAIV and CMS-64.9P WAIV. The MBES/CBES system is not programmed to allow such adjustments to post to lines 9 or 10C on forms CMS-64.9 WAIV and CMS-64.9P WAIVE. In order for these offsets to be credited to waiver expenditures, they must be reported on line 10-B. This alternate procedure allows claims to be included in the CMS-64 Waiver Expenditure Report Schedules A, B, and C. Waiver Schedule A provides waiver expenditures claimed for the current quarter. Waiver Schedule B provides a cumulative total for previous waiver expenditures as reported, current quarter expenditures, and the total expenditures-to-date. Waiver Schedule C provides a breakout of waiver expenditures-to-date by waiver name, by demonstration year, and totals for both total computable and federal share. For other cost settlements (i.e., those not attributable to the budget neutrality agreement), the adjustments are reported on lines 9 and 10-C., as instructed in the State Medicaid Manual.

### **Administrative Expenditures**

At the request of CMS and as agreed to by AHCCCS, effective with the implementation of the acute care expansion on April 1, 2001, all administrative expenditures and adjustments for the total Medicaid program are reported in two categories. Using a cost allocation method developed by the state and reviewed by CMS, administrative expenditures are allocated as follows:

- The costs of administering the acute care program excluding the MIPS, the Freedom to Work and the Breast and Cervical Cancer Treatment Programs.
- The combined costs of administering ALTCS, MIPS, Freedom to Work and Breast and Cervical Cancer Treatment programs.

Administrative expenditures relating to the waiver are not subject to the budget neutrality cap. Non-waiver expenditures are reported on the Forms CMS-64.10 and CMS-64.10P and waiver expenditures are reported on the Forms CMS-64.10 WAIV and CMS-64.10P WAIV. The Forms CMS-64.10 and CMS-64.10P require no unique naming or numbering conventions. The following table lists the Forms CMS-64.10 WAIV and CMS-64.10P WAIV with numbering and naming conventions:

CMS Form	Waiver Name	Waiver Type	Waiver Number and Extension**
64.10 WAIV	ACP	1115	11W00032/9-**
64.10 WAIV	ALTCS/MIPS	1115	11W00032/9-**
64.10P WAIV	ACP	1115	11W00032/9-**
64.10P WAIV	ALTCS/MIPS	1115	11W00032/9-**

**Waiver Number Extension	Demonstration Year
01	April 1, 2001 – September 30, 2002
02	October 1, 2002 – September 30, 2003
03	October 1, 2003 – September 30, 2004
04	October 1, 2004 – September 30, 2005
05	October 1, 2005 – September 30, 2006

### Member Month Reporting

The budget neutrality agreement in Attachment A, Item 3 of the Special Terms and Conditions requires that member months subject to the budget neutrality cap be reported to CMS on a quarterly basis 30 days after the end of each quarter. Member months used to calculate the budget neutrality limit include only those member months for individuals enrolled in the current acute care program that are categorically eligible under the TANF/SOBRA and SSI waiver groups. Member months for non-categorical individuals who are eligible because of the 100% FPL expansion are not included.

The member months reported are prospective capitation member months and all fee-for-service member months. For consistency with the per member per month (PMPM) calculations included in the Special Terms and Conditions, the prior period capitation member months are not reported. The fee-for-service member month reporting will differ slightly from the calculations used to determine the PMPM rates included in the Special Terms and Conditions because of the requirement to use member months (as opposed to enrollment) and the inclusion of the small fee-for-service population that is neither IHS nor FES. For example:

Fee-for-service member months are calculated as one member month for each individual who is eligible to receive services for an entire month and a percentage of one-member months for each individual who is eligible to receive services for a partial month as follows:

Individual	Eligible Dates	Days in Month	PM/PM Calculation
1	April 1 through April 30	30/30	1.0000 Member Month
2	April 1 through April 23	23/30	0.7666 Member Month
3	April 12 through April 30	19/30	0.6333 Member month
Total Member Months			2.3999

Capitation member months for the prospective eligible periods only are calculated as one member month for each eligible individual for whom a capitation payment is made and a percentage of one-member month for each individual for whom a partial capitation payment is made as follows:

Individual	Eligible Dates	Days in Month	PM/PM Calculation
1	May 1 through May 31	31/31	1.0000 Member Month
2	May 1 through May 18	18/31	0.5806 Member Month
3	May 1 through May 9	9/31	0.2903 Member month
Total Capitation Member Months			1.8709

A report is generated from PMMIS each quarter summarizing the eligibility member months for each eligibility category. The member months are then reported on the narrative form CMS-64 Narr in the following format:

Budget Neutrality Year	Quarter Ending	AFDC/SOBRA Member Months	SSI Member Months	Total
1	June 30, 2001	117,270	266,041	383,311

### **Monitoring Budget Neutrality**

The budget neutrality agreement defines the maximum allowed federal expenditures for the populations included in the budget neutrality agreement. To calculate the budget neutrality limit, the following calculations are performed:

- For each budget neutrality year, the estimated PMPM for the AFDC/SOBRA and SSI populations is multiplied by the effective FMAP rate for that budget neutrality year to calculate the Federal Share PMPM.
- The Federal Share PMPM is multiplied by the actual member months subject to the budget neutrality agreement as reported on the CMS-64 to calculate the Medical Assistance Payments (MAP) portion of the limit.
- The sum of the MAP portion of the limit and the Federal Share of the disproportionate share hospital allotment for that budget neutrality year is equal to the budget neutrality limit.
- The sum of the budget neutrality limits for the five waiver periods is the budget neutrality limit for the five and one-half year waiver period.

This calculation, submitted as a stand-alone report formatted to CMS specifications allows CMS and Arizona to monitor the state's performance in relation to the budget neutrality annual expenditure targets and five and one half -year cap.

### **Statistical Reporting**

Effective January 1, 1999, states are required to submit Medicaid eligibility and claims information to CMS through the Medicaid Statistical Information System (MSIS). Section 2700 of the State Medicaid Manual details the MSIS reporting requirements. The state follows the reporting requirements outlined in the State Medicaid Manual when submitting eligibility and claims information for its expansion populations.

## II. HIFA

### Background

The state has established a monitoring process to ensure that expenditures for the HIFA I and II populations do not exceed available Title XXI funding (i.e., the Title XXI allotment and reallocated funds) and the appropriated state match. The state will use Title XXI funds to cover services for the SCHIP and HIFA I and II populations in the following priority order:

- 1) Children eligible under the title XXI State plan (KidsCare).
- 2) Beginning January 1, 2003 parents of Medicaid or KidsCare eligible children with family income between 100 and 200 percent of the FPL. These parents are not eligible for Title XIX or under the KidsCare Children's program.
- 3) Beginning November 1, 2001, childless adults with income between 40 to 100 percent of the FPL who are eligible under the Medicaid section 1115 eligibility expansion. For purposes of this document, these are defined as individuals over age 18 without dependent children.

The state will not close enrollment, institute waiting lists, or decrease eligibility standards for KidsCare eligible children covered under Title XXI State plan while the HIFA amendment is in effect.

For the purpose of administering this priority system, no distinction will be made between parents of Medicaid children and parents of SCHIP children. The state has the discretion for the Medicaid or SCHIP parents to:

- Lower the federal poverty level used to determine eligibility.
- Suspend eligibility determination and/or intake into the program.
- Discontinue coverage.

Before taking any of the above actions, Arizona will provide a 60-day notice to CMS. If the HIFA parent group is repealed or state matching funds not approved, Arizona will no longer use Title XXI funding for the HIFA I waiver group.

For the childless adults, Title XIX federal matching funds will be used if Title XXI funding is not available. However, these individuals must be otherwise Medicaid eligible under either the 100% of FPL expansion approved on January 18, 2001 or any other Medicaid eligibility group in the Arizona State Plan. Funding for childless adults using Title XXI funds may resume at a future date if Title XXI funding is available.

AHCCCS will monitor and report on reducing the rate of uninsurance. If 100% of FPL expansion data is readily available, AHCCCS will also monitor the private insurance market (e.g., changes in employer contribution levels), (trends in sources of insurance, etc. and other related information) in order to provide a context to interpret progress toward reducing uninsurance. AHCCCS will also continue to monitor substitution of coverage (i.e., participants

dropping private coverage). In addition, data on the HIFA populations will be separately identified in the monthly Eligibility and Enrollment Reports.

### **Financial Requirements**

The state will provide quarterly expenditure reports using the Form HCFA-21 to report total expenditures for services provided under the approved KidsCare State Plan and the HIFA amendment. CMS will provide FFP only for Arizona HIFA I and II expenditures that do not exceed the state's available Title XXI funding.

In order to track expenditures under the HIFA demonstration, the state will report expenditures through the Medicaid Budget and Expenditure System (MBES), as part of the routine quarterly HCFA-21 reporting process. Title XXI expenditures will be reported for each HIFA eligibility group on separate Forms HCFA-21 Waiver/HCFA-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

All claims for expenditures related to HIFA (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Further, all claims for services period (including cost settlements) must be made within two years after the conclusion or termination of the HIFA demonstration. During this two-year period, the state must continue to identify separately net expenditures related to dates of service on the Form HCFA-21.

The standard SCHIP funding process will be used during the HIFA demonstration. Arizona must estimate matchable SCHIP expenditures on the quarterly Form HCFA-21B. On a separate HCFA-21B, the state will provide updated estimates of expenditures for the HIFA I and II populations. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form HCFA-21 quarterly SCHIP expenditure report. CMS will reconcile expenditures reported on the Form HCFA-21 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

The state will certify state/local monies used as matching funds for the HIFA demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

Arizona will be subject to a limit on the amount of federal Title XXI funding that the state may receive for HIFA expenditures. Title XXI funding available for the HIFA I and II populations are limited to the state's available allotment, including current reallocated funds. For the purpose of administering the priority system, no distinction will be made between parents of Medicaid children and parents of SCHIP children. If the state exhausts the available Title XXI funding, no further enhanced federal matching funds will be available for costs of the KidsCare program or the HIFA I and II populations until the next allotment becomes available. Title XIX federal matching funds will be used for the childless adults if Title XXI funding is exhausted.

Total expenditures for outreach and other reasonable costs to administer the Title XXI State Plan and the HIFA II population may not exceed ten percent of total Title XXI expenditures.

### **Expenditures for Direct Medical Services**

All claims related to the HIFA I and II populations are reported as a part of the state's quarterly CMS-21 expenditure report via the MBES/CBES. Non-waiver expenditures are reported on the Forms CMS-21 and CMS-21P and waiver expenditures are reported on the Forms CMS-21 Waiver and CMS-21P Waiver. The Forms CMS-21 and CMS-21P require no unique naming or numbering conventions. The CMS-21 forms, form names, waiver numbers and demonstration years are defined in the following table:

CMS Form	Waiver Name	Waiver Number	Waiver Type
21 WAIVER	HIFA1	21W00009/9-01	1115
21 WAIVER	HIFA Parents	21W00009/9-01	1115
21P WAIVER	HIFA1	21W00009/9-01	1115
21P WAIVER	HIFA Parents	21W00009/9-01	1115

The tenth character of “9” in the waiver number designates CMS Region IX. Budget neutrality is not a requirement of the HIFA waiver and CMS has not defined demonstration years, therefore, the last two digits of the waiver number, referred to as the waiver number extension, are not unique to demonstration years and are defaulted to “01”.

### **Budgeted Expenditures**

Budgeted expenditures are reported on separate CMS Form 21B forms for the child and waiver populations as follows:

CMS Form	Program Name	Program Number
21B	SCHIP (KidsCare)	AZ1
21B	HIFA I (Childless Adults)	AZ3
21B	HIFA II (Parents of TXIX/TXXI Children)	AZ5

The HIFA waiver priority for budgeted expenditures, outlined in the Special Term and Condition Item 24, is incorporated in the budget development and monitoring as follows:

- The budget is developed on an annual basis and is revised, as necessary, to reflect material variances in projected enrollment in the SCHIP base, HIFA 1 and HIFA II populations. The budget projections extend through the term of the HIFA waiver.
- The SCHIP allotments are recorded/projected through the term of the HIFA waiver.
- The budget and allotment data are combined into the “CMS Budget Template”, a tool used to forecast the available allotment for each of the three populations over the term of the waiver.
- A determination is made, using the CMS Budget Template, of the availability of Title XXI allotment for HIFA I and II populations after fully funding the SCHIP KidsCare base population.

- Actual expenditures and the variance between budgeted and actual expenditures are monitored on a monthly basis.
- Once Title XXI funding for the HIFA I population is exhausted, this group will revert to Medicaid funding and related expenditures will be claimed on the CMS-64. Funding for childless adults using Title XXI funds may resume at a future date if Title XXI funding is available.

### III. REIMBURSEMENT FOR CRITICAL ACCESS HOSPITALS

Subject to the availability of state funds, beginning May 1, 2002, supplemental payments will be made to in-state hospitals, certified by Medicare as Critical Access Hospitals (CAHs) under 42 CFR 485, Subpart F and 42CFR 440.170(g). These supplemental CAH payments shall be made in addition to the other payments described in Attachment 4.19-A (inpatient hospital) and 4.19-B (outpatient hospital). Supplemental payments shall be made based on each CAH designated hospital's percentage of total inpatient and outpatient Title XIX reimbursement paid relative to other CAH designated hospitals for the time period from July 1 through June 30 of each year.

Funding will be distributed based on the number of CAH-designated hospitals in each month and their Medicaid utilization. Because there may be a different number of CAH-designated hospitals each month, the hospital-specific weightings and payments may fluctuate from month to month. The calculations will be computed monthly and the distribution of the CAH dollars to the CAH-designated hospitals will be made on a quarterly basis.

AHCCCS will include the amount of any supplemental CAH payment when calculating disproportionate share hospital payments for CAH designated hospitals.

AHCCCS will allocate the amount available through legislative appropriation in the following manner:

1. Divide the total current year CAH allocation by 12 to get a monthly CAH distribution.
2. Gather all adjudicated inpatient and outpatient claims/encounters with dates of service from July 1 through June 30 of the prior state fiscal year for each hospital that has CAH status in the current fiscal year.
3. Divide each hospital's total adjudicated claim/encounter amounts (described in step 2) by 12 to get an average monthly paid claims amount.
4. Quarterly, determine which hospitals have CAH status for each month in the quarter.
5. For each month in that quarter, divide each eligible hospital's average monthly paid claims amount (as determined in step 3) by the total of all hospitals' average monthly paid claims amount for that month to establish the hospital's monthly utilization percentage.
6. Multiply that monthly utilization percentage by the monthly CAH distribution (described in step 1).
7. In the event that an additional hospital achieves CAH status during the current CAH distribution year, gather that hospital's inpatient and outpatient adjudicated claims/encounters with dates of service from July 1 through June 30 of the prior state fiscal year and divide by 12 to get that hospital's average monthly paid claims amount. Add that amount to the listing of monthly eligible hospitals starting in the month it is eligible. Go to step 5.

AHCCCS will request CMS approval prior to making any supplemental payments appropriated by the Arizona legislature.

#### IV. AHCCCS DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

##### Background

Section 1923 of the Social Security Act sets forth federal requirements designed to aid hospitals that serve a disproportionate share of low-income and Medicaid patients. Federal requirements specify the following minimum standards for determining which hospitals qualify for disproportionate share:

- Those hospitals whose mean Medicaid Utilization Rate exceeds the state's mean Medicaid Utilization Rate plus one standard deviation; or
- Those hospitals whose Low Income Utilization Rate is more than 25%.

In addition, beginning in fiscal year (FY) 1996, the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) added the requirement that a hospital must have a Medicaid Utilization Rate of at least one percent in order to be eligible for a disproportionate share payment.

A hospital's Medicaid Utilization Rate is the number of inpatient days that were paid for by Title XIX Medical Assistance divided by the total number of the hospital's inpatient days. Because Medicaid is not the primary payer, days associated with Medicare crossover claims and encounters are not included.

$$\text{Medicaid Utilization} = \frac{\text{Title XIX Days}}{\text{All Payor Days}}$$

The Low Income Utilization Rate is the sum of the ratio of the total AHCCCS revenues (e.g., Medicaid, Medicare Crossovers, MN/MI and EAC/ELIC; excluding Title XXI) and county and state subsidies to net inpatient revenues plus the ratio of gross charity care revenue to gross patient revenues. (Note: MN/MI, EAC/ELIC will not be used for calculations after FY 04.) For county facilities, net inpatient revenues include county subsidy payments. The Low Income Utilization Rate is calculated as follows:

$$\text{Low Income Utilization} = \frac{\text{Total AHCCCS Revenue} + \text{County \& State Subsidies} + \text{Other Gov't Revenue}}{\text{Net Inpatient Revenue} + \text{Other Gov't Revenue}} + \frac{\text{Gross Charity Revenue}}{\text{Gross Patient Revenue}}$$

States are allowed to establish disproportionate share criteria that differ from the federal requirements, but state-specific criteria must be at least as generous as the federal standards. AHCCCS first implemented a disproportionate share program in FY 1992. Arizona uses state-specific criteria as allowed under the law to provide for a distinction between public and private hospitals, and to create a third private hospital group. Each year a pool of funds is established

for disproportionate share payments to hospitals. This pool is apportioned to hospitals that qualify either under the federal criteria or under the state's criteria based on a relative weighting.

AHCCCS worked with HCFA/CMS on the DSH methodology in 1991/1992, this methodology has not changed since then. Arizona's DSH criteria established 3 private hospital distribution pools and 1 public hospital distribution pool, the eligibility criteria for these pools has not changed since 1992. Two of these pools are "mandatory federal DSH pools", and the other 2 are "optional State defined DSH pools". AHCCCS reviews the processes, and the specific financial and utilization data used in the calculations as defined in the Operational Protocols on an annual basis when the DSH payments are calculated and distributed.

In addition, OBRA 93 established rules limiting the total disproportionate share payment that a hospital can receive. Disproportionate share payments are limited to no more than the cost of providing hospital services to patients who are either eligible for medical assistance under a state plan or have no health insurance for the services provided, less payments received under Title XIX (other than DSH payment adjustments). These limits went into effect in FY 1995 for public hospitals, and in FY 1996 for private hospitals.

### **Qualifying Criteria**

A hospital in Arizona may qualify for disproportionate share payments by meeting one of two federally mandated criteria or one of two optional, state-specific criteria. One group was established for each of the four criteria. If a hospital qualifies for more than one group, the hospital is categorized into the group that maximizes its disproportionate share payment.

The qualifying criteria for each of the four groups are described below:

- |                |   |
|----------------|---|
| <i>Group 1</i> | This group is based on the federally mandated criterion of the state's mean Medicaid (Title XIX) Utilization Rate plus one standard deviation. The Medicaid Utilization Rate is defined as a hospital's Medicaid inpatient hospital days divided by the hospital's total inpatient hospital days.   |
| <i>Group 2</i> | This group is based on the federally mandated criterion targeting those hospitals whose Low Income Utilization Rate is more than 25%. The Low Income Utilization Rate is defined as the sum of the two fractions: 1) a hospital's low-income revenue (total AHCCCS, state and county revenues) as a percentage of net inpatient revenue, and 2) the percentage that gross charity care revenue contributes to gross hospital revenue. |
| <i>Group 3</i> | This group is one of the state's optional groups. Acute care general hospitals (psychiatric and rehabilitation facilities excluded) qualify if <b>either</b><br><br><ol style="list-style-type: none"><li>1. Their Low Income Utilization Rate is greater than the statewide mean Low Income Utilization Rate, <b>or</b>,</li></ol>   |

2. They provide at least 1.0% of the total Medicaid days across hospitals in the state.

Because Group 3 criteria are less restrictive than the criteria for either Group 1 or Group 2, all hospitals that qualify for either Group 1 or Group 2 will also qualify for Group 3. As mentioned above, the actual group placement for a hospital is determined by which placement results in the highest payment.

*Group 4* This group is also one of the state's optional groups and consists only of one state and one county hospital (Maricopa Medical Center and Arizona State Hospital).

The Medicaid Utilization Rate and Low Income Utilization Rate for each hospital are based on data from each hospital's Uniform Accounting Report (UAR) and AHCCCS claims and encounter data for each hospital's fiscal year end from 2 years prior (most recently available information). The UAR is an annual financial report, which is mandated by statute and filed with the Arizona Department of Health Services. The sources for specific data elements used in the calculations for Groups 1 through 3 are described below.

**Medicaid Utilization Rate (*Group 1*)**

Total Title XIX Days	Calculated from claims and encounter data plus CRS days.
All Payer Days	UAR

**Low Income Utilization Rate (*Groups 2 and 3A*)**

Charity Care Revenue	UAR
Gross Patient Revenue	UAR
Net Inpatient Revenue	Calculated from UAR data.
Total AHCCCS Revenue	Calculated from claims and encounter data (excludes Title XXI).
County Revenue	Provided separately by the county facilities.
Other Government Revenue	CRS plus Other Revenues obtained from DHS.

Total AHCCCS Revenue is the sum of the payments for Title XIX, MN/MI, EAC, and ELIC claims and encounters; graduate medical education; and supplemental Critical Access Hospital (CAH) payments, as appropriate. (Note, MN/MI, EAC and ELIC will not be used for calculations after FY 04.)

### Statewide Percentage of Title XIX Days (*Group 3B*)

Total Title XIX Days	Calculated from claims and encounters (same calculation as for Medicaid Utilization Rate).
Sum of Total Title XIX Days	The sum of all Total Title XIX Days from all hospitals that could potentially qualify.

Group 4 consists of all public hospitals. Additional calculations are not required to determine whether the facility qualifies.

A facility must also be Medicare-certified (or Medicare certifiable) on the date the DSH payment is made to be eligible to receive its full DSH payment. If a facility is Medicare-certified for the full federal fiscal year for which DSH payments are made but lost that certification after the start of the next fiscal year, that facility is eligible for its full DSH payment provided that DSH payments have been finalized prior to the loss of certification. This is true even if AHCCCS has not yet mailed the payment to the hospital.

If a facility that is eligible for a DSH payment changes ownership, the DSH payment will be distributed to the entity that owns the facility at the end of the federal fiscal year for which the payment is made, assuming that the facility continues to provide services to the same populations it served prior to the change of ownership through the end of the federal fiscal year for which the DSH payment is made. Facilities should consider this information when negotiating ownership changes.

### Disproportionate Share Payments

DSH funds are allocated to four pools, three private and one public facility pool. The private hospital pool totals are set by AHCCCS as authorized by the Arizona Legislature. AHCCCS reserves the right to reallocate monies within a pool, across the private pools or both for any reason. In addition, in the event that litigation requires AHCCCS to reimburse a facility, or facilities, the settlement will result in a reallocation of monies such that the current DSH allotment is not exceeded. The amount that each hospital receives from the pool for which they qualify is determined by a weighting method that considers both the amounts or points over the threshold and volume of services, which, depending upon the group classification of the facility, is either measured by Title XIX days or net inpatient revenue.

The minimum payment amount for private facilities qualifying for DSH is \$5,000.

To determine the allocation for the public acute care hospital, the relative allocation percentage for each hospital is computed under each of the qualifying criteria for the three private groups using Medicaid Utilization Rate, Low Income Utilization Rate, and Percentage of Statewide Medicaid Days. The average of these percentages is used to compute the final allocation for each hospital, not to exceed the OBRA 93 limit for each hospital. The allocations are also made in accordance with the levels determined by the Arizona Legislature. The Arizona State Hospital is limited by the Federal Institution for Mental Disease (IMD) payment limits.

### **OBRA 93 Payment Limits**

As discussed previously, the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) contains provisions that affect the qualification of disproportionate share hospitals and the amount of payment. The qualification change is that for state fiscal years beginning in 1994, a facility may not be qualified as a DSH facility unless it has a Medicaid Utilization Rate of at least one percent.

Another provision of OBRA 93 is that a hospital's DSH payment must be limited to the difference between the cost of providing services to the uninsured and the Medicaid payments received. In FY 1995 this applied only to public facilities, but beginning in FY 1996 this limit applied to both public and private facilities. AHCCCS will calculate the OBRA limits for public hospitals pursuant to the Benefits Improvement Protection Act of 2000. Section 701(c) for payments beginning FY04 and FY05.

As the final step in the DSH payment calculation methodology, the payment's proportion of the OBRA 93 limit is calculated as the ratio of the unadjusted DSH payment to the total cost of low-income care less Medicaid payments:

$$\frac{\text{unadjusted DSH payment}}{\text{cost of low income care} - \text{Title XIX payment}}$$

The facility's cost of low-income care is the sum of the cost of services to Medicaid patients and the cost of services to uninsured patients, including unreimbursed graduate medical education costs. The proportion must be one or less than one for facilities to be in compliance with the OBRA 93 provision.

The cost of low-income care is calculated using the claims and encounter data submitted by each facility as well as hospital-specific cost-to-charge ratios, and Medicare Cost Report data. The total cost includes the costs of the following components: Title XIX, MN/MI, EAC, ELIC, charity care, and county and other government payments. (Note: MN/MI, EAC and ELIC will not be used for calculations after FY 04.)

The cost of low-income care for public hospitals also includes the professional component of expenses, which is eliminated from inpatient expenses as a section A-8 adjustment on the Medicare Cost Reports.

Hospitals are determined to be ineligible for DSH payments if their total Title XIX payment exceeds their cost of care (i.e., their costs of providing low income care have been fully reimbursed.)

## V. COST SHARING

### Background

Federal law and regulations set the parameters that states must follow in order to impose cost sharing on traditional Medicaid populations and on SCHIP children authorized by the Title XXI State Plan. These regulations do not apply to expansion populations added by an 1115 Research and Demonstration waiver funded by Title XIX or Title XXI funds.

For children covered through the Arizona SCHIP program (KidsCare), cost sharing requirements are included in the KidsCare State Plan. The Medicaid State Plan also includes cost sharing amounts for the traditional Medicaid population.

In 2003, the Arizona legislature directed AHCCCS to establish cost sharing requirements approved by CMS for the AHCCCS enrolled population. The current cost sharing requirements are described below.

If at any time a lawsuit or preliminary injunction requires AHCCCS to cease the implementation of a particular cost sharing measure, AHCCCS will make the necessary adjustments to comply with the court ruling.

### Co-payments

As of October 1, 2003, the following individuals, approved as part of the 1115 expansion waiver, are subject to these co-payments:

#### Expansion

- Childless adults with income up to 100% of the FPL who are not categorically linked to Medicaid, including Native American adults who are enrolled in an AHCCCS health plan.
- Individuals eligible for the Medical Expense Deduction program added by the 1115 expansion waiver, including Native American adults who are enrolled in an AHCCCS health plan.

Services	Co-Payments Amount
Generic prescriptions or brand name if generic is not available	\$4 per prescription
Brand name prescriptions when generic is available	\$10 per prescription
Non-emergency use of the emergency room	\$30 per visit
Physician office visit	\$5 per visit
All other services	No charge

Providers may deny a service listed above if the individuals do not pay the required co-payment. Providers will collect the mandatory co-payments and AHCCCS will adjust accordingly the capitation rates paid to the health plans to reflect the estimated collection amount.

A preliminary injunction was signed in the Newton Nations et. al. v. Rodgers lawsuit on April 20, 2004, immediately prohibiting AHCCCS from imposing the above stated co-payments on the expansion populations. These co-payments were stopped and the expansion populations now follow the same co-payments imposed on traditional Medicaid. This change means that providers cannot deny services due to the inability to pay a co-payment.

#### HIFA II Parents

For individuals eligible under the HIFA II parent program, the following co-payment applies:

Services	Co-Payments Amount
Non-emergency use of the emergency room	\$1 per visit

#### **Premiums**

As of January 1, 2003, parents eligible for HIFA II are assessed the monthly premiums specified below in order to retain eligibility. The five percent cap on total out-of-pocket required in Title XXI does not apply to the cost sharing under this Operational Protocol for HIFA II parents. This operational protocol replaces the amounts included in the HIFA template for HIFA II parents. The monthly premiums imposed for SCHIP children enrolled in KidsCare are addressed in the KidsCare State Plan.

Income Level	Monthly Premium per Member
100%-150% FPL	\$15
150%-175% FPL	\$20
175%-200% FPL	\$25

A premium paid in advance is nonrefundable, unless the member is disenrolled at least 15 days prior to the end of the month of coverage. A premium paid during a grievance, appeal or request for hearing is nonrefundable.

#### **Populations exempt from premiums**

Medical Expense Deduction (MED)  
AHCCCS Care

#### **Enrollment Fees**

Effective January 1, 2005, enrollment fees were implemented for applicants for HIFA II coverage. Enrollment fees are imposed as follows:

- New applicants for HIFA II;
- Previous enrollees who re-apply for HIFA II are assessed an enrollment fee if they have not had HIFA II coverage in the previous 24 months;
- The enrollment fee is equal to the amount of one monthly premium;
- The enrollment fee is billed with the first month's premium; and
- Native Americans are exempt from the enrollment fee.

**Grievance and Appeals**

An AHCCCS member or their representative can make a written request for a hearing to challenge the mandatory co-payment or premium. Services will continue during the appeal process.

The request for a hearing must be signed by the individual or their representative and submitted on the form provided by AHCCCS, or in another format, if the request is dated and includes the person's name, AHCCCS ID number, Social Security Number, mailing address, phone number and the reason a hearing is being requested.

The written request for a hearing may be mailed, faxed or delivered to:

AHCCCS Administration  
Office of Legal Assistance, MD 6200  
701 East Jefferson  
Phoenix, Arizona 85034  
FAX: (602) 253-9115

**Public Involvement**

In January 2002, in response to a deficit approaching \$1 billion, the Arizona legislature identified several areas where the state could save money in all state programs. The legislature discussed a number of cost savings measures specific to AHCCCS, including reducing eligibility levels, cutting optional Medicaid services, dropping all home and community-based services and the possibility of adding new cost sharing requirements. During their deliberations, the legislature held public hearings about the cost sharing options and discussed the different measures during caucuses open to the public.

In the 2002-2003 Appropriations' legislation, the Arizona legislature directed AHCCCS to submit a Cost Sharing Report to the Joint Legislative Budget Committee (JLBC) by October 1, 2002 that discussed the various options for co-payments, deductibles, coinsurance, premiums and any other permissible cost sharing arrangements for AHCCCS' enrollees. AHCCCS presented the Cost Sharing Report to JLBC on October 1, 2002. In December, 2002, JLBC held a public hearing, made copies of the Cost Sharing Report available to the public and heard testimony from various interested parties on the cost sharing options contained in the Report. At the conclusion of the hearing, the JLBC Committee instructed AHCCCS to begin discussions with CMS to determine the permissibility of the various options.

In June 2003, the legislature formally added statutory language that directed AHCCCS to submit a waiver request to CMS requesting permission to impose new cost sharing amounts. On May 2, 2003, AHCCCS submitted a waiver request to CMS noting that it was subject to the approval of the legislature. AHCCCS posted the waiver request on the AHCCCS web site in June 2003 after the legislature approved the Appropriations legislation and transmitted it to the Governor.

In the past, AHCCCS met with several constituent and provider groups about the legislative mandate and scheduled four public hearings throughout the state to inform the public about the new cost sharing requirements. Proposed rules were published on the AHCCCS web site on September 4, 2003 and public hearings were held on September 24, 2003. Public hearings were held in Phoenix on January 12, 2004 regarding the February 1, 2004 premium increase. Public hearings were scheduled for May 7, 2004, regarding premium increases effective July 1, 2004. AHCCCS also conducted a series of public forums that included a discussion on enrollment fees.

Please note that Native Americans enrolled with the Indian Health Service or eligible under the HIFA II or Kids Care program are exempt from cost-sharing. However, all federally recognized Tribal Governments were given notice about the proposed changes and offered the opportunity to attend the public hearings in conjunction with the other constituents and providers. Some tribal members and representatives from the Indian Health Services also participated in Provider Forums that discussed cost sharing measures.

---

## XI. Evaluation Guidelines

The State of Arizona understands that either the state or an independent contractor shall conduct an evaluation of Arizona's 1115 Research and Demonstration Waiver. The purpose of this section is to suggest a framework for structuring an evaluation of the effectiveness of the Demonstration. The state suggests the following evaluation activities for consideration.

### A. Research Questions and Expected Outcomes

Coverage: To what extent is the Demonstration effective in increasing coverage to the targeted populations?

It is expected that:

- The overall rate of uninsured in Arizona has decreased as well as the rate of uninsured among those populations targeted in the demonstration.

Coverage could be evaluated through qualitative and quantitative measurement of:

- Enrollment trends
- The rate of uninsured in Arizona and other trends data regarding the uninsured in Arizona

Access: To what extent is the Demonstration resulting in satisfactory access to services?

It is expected that:

- Access to primary care physicians is satisfactory
- Access to Home and Community Based services is satisfactory
- Access to other treatment and services is satisfactory

Access could be evaluated through qualitative and quantitative measurement of:

- Data from various agency reviews, reports, and performance improvement project findings

Quality: To what extent is the Demonstration impacting the provision of quality care?

It is expected that:

- The Demonstration provided a model that leads to a positive impact on quality care
- Member satisfaction with quality of care is high
- Provider satisfaction with the demonstration is high

Quality could be evaluated through qualitative and quantitative measurement of:

- Data from agency reviews, reports and performance/improvement projects
- Member surveys
- Provider surveys
- Clinical assessment of health outcomes

Cost Effectiveness: To what extent is the Demonstration successful in being cost-effective?

It is expected that:

- The Demonstration provides a model that is cost-effective to the federal government, the Arizona State government, and Arizona tax payers.

Cost effectiveness could be measured through measurement of:

- Cost in Arizona compared to other states
- Capitation rate increases compared to health care inflation rate.

## **B. Potential Data Sources**

- Enrollment data
- Utilization data
- Member surveys
- Provider surveys
- External quality reviews
- Complaint reports
- Disenrollment reports
- Quality of Care and Performance Improvement Reports and Reviews

---

# Appendices

Appendix I – AHCCCS History.....	1
Appendix II – Support Letters.....	3
Appendix III – Agency Organizational Chart.....	11
Appendix IV – GSA Maps.....	12
Appendix V – ALTCS Premium Proposal.....	14
Appendix VI – Disregard of Interest Proposal.....	16
Appendix VII – Employer Sponsored Insurance Proposal.....	18

---

# Appendix I

## AHCCCS HISTORY

<b>1974</b>	Arizona legislature approves participation in Medicaid but does not provide State funding.
<b>1981</b>	Legislature approves and funds AHCCCS as a prepaid, capitated managed care demonstration project under Medicaid.
<b>1982</b>	Three year demonstration waiver is approved by the Health Care Financing Administration (HCFA) enabling the implementation of the AHCCCS acute care program on October 1, 1982.
<b>1984</b>	AHCCCS becomes an independent State agency (previously a Division of the Department of Health Services).
<b>1985</b>	AHCCCS demonstration waiver extended by HCFA for two additional years through September 30, 1987.
<b>1987</b>	Waiver request includes proposal for Arizona Long Term Care System (ALTCS). ALTCS proposal is approved by HCFA which also approves demonstration waiver for an additional year.
<b>1988</b>	Beginning January 1, 1988, small employers are allowed to purchase medical coverage for their employees from AHCCCS Health Plans through Healthcare Group.
<b>1988</b>	AHCCCS receives HCFA approval of waiver through September 30, 1993 (5years).
<b>1988</b>	ALTCS program implemented on December 19, 1988 for the developmentally disabled and January 1, 1989 for the elderly or physically disabled.
<b>1989</b>	The Final Report on the AHCCCS first five years, program costs (excluding administrative costs were 6% less than the costs of a traditional Medicaid program and AHCCCS provided a higher quality of care for children and better access to routine care than a traditional Medicaid program.
<b>1993</b>	Waiver extension approved by HCFA through September 30, 1994.
<b>1993</b>	Laguna Research Associates Second Outcome Report showed that AHCCCS was able to constrain cost increases by 44.1% during the first nine years of the program when compared with a traditional Medicaid program.
<b>1994</b>	Beginning October 1, 1994, all counties had at least two acute care health plans in which members could choose to enroll.
<b>1994</b>	HCFA approved the extension of the AHCCCS waiver through September 30, 1997.
<b>1995</b>	Behavioral health services available to all Title XIX eligible members effective October 1, 1995.
<b>1995</b>	A GAO Report cited AHCCCS for its success in containing costs, and providing access to mainstream medical care.
<b>1996</b>	Laguna Research Associates, in their Final Report, finds that their evaluations of the program indicate success in delivering services statewide to Medicaid eligibles in all eligibility groups and that the cumulative total cost savings estimated for the program was nearly \$500 million as of 1993.
<b>1997</b>	The first statewide survey of AHCCCS acute care members was conducted in 1996 by Arizona State University. The overall survey results, which are based on interviews with over 14,000 members, are very favorable to the AHCCCS program, with at least three-fourths of the respondents giving a rating of "good" or "very good" in response to the six questions which rated the overall quality of AHCCCS health plans.

<b>1998</b>	In the BBA of 1997, the federal government established separate funding under Title XXI for states to create program's for uninsured children under the age of 19. Arizona implemented its version of a State Children's Health Insurance Program ("KidsCare") on November 1, 1998. During the first year, children under 150 percent of the federal poverty level (FPL) will be covered.
<b>1999</b>	In February 1999, CMS extended the waiver until the end of September 1999 and approved an increase on the HCBS cap to 50 percent.
<b>1999</b>	On October 1, 1999, the income eligibility level for SCHIP was raised to 200 percent of FPL as a result of state legislation passed in the 1999 session. Premiums are required for persons who have an FPL above 150 percent of FPL.
<b>1999</b>	The Hawaii Arizona PMMIS Alliance (HAPA) project began. The project is a collaboration by the Medicaid agencies in Hawaii and Arizona to modify Arizona's information system to support the Hawaii QUEST program. First phase completed December 2000.
<b>2000</b>	In July 2000, CMS approved a 3-year waiver extension for the period from October 1, 1999 through September 30, 2002 and removed the HCBS cap on the ALTCS program.
<b>2001</b>	In January 2001, CMS approved AHCCCS' request to expand eligibility to 100 percent of the FPL for the acute care program and waive the requirement for prior quarter coverage to new enrollees in both the acute and ALTCS programs. In December, CMS extended AHCCCS 1115 waiver authority through September 30, 2006.
<b>2002</b>	In January 2002, AHCCCS launched the Breast and Cervical Cancer Treatment program for women who are screened and diagnosed as needing treatment by the Arizona Department of Health Services Well Women Health check program.
<b>2002</b>	The AHCCCS Freedom to Work program, which allows disabled individuals to work without losing their benefits, is implemented.
<b>2003</b>	On January 1, 2003 eligibility for parents of SCHIP children with household income up to 200% FPL was established.
<b>2004</b>	On July 1, 2004, AHCCCS began reimbursing outpatient hospital services using a hospital-specific cost-to-charge ratio in an effort to control hospital charges.

## **Appendix II**



Arizona Hospital and Healthcare Association

February 6, 2006

Anthony D. Rodgers  
Director  
Arizona Health Care Cost Containment System  
801 East Jefferson  
Phoenix, AZ 85034

Dear Tony,

The Arizona Hospital and Healthcare Association, which represents hospitals and health systems throughout Arizona, is pleased to support the Arizona Health Care Cost Containment System (AHCCCS) in its effort to seek a five-year renewal of the current 1115 research and demonstration waiver.

For nearly 25 years, AHCCCS has served as a model for Medicaid programs across the country, and has achieved national prestige through its successful delivery of cost-effective healthcare coverage to low-income families.

A true public-private partnership, AHCCCS works in collaboration with Arizona's hospital and medical community to deliver cost-effective healthcare services to its one million enrollees. Throughout its history, AHCCCS has demonstrated that it is a good value not just for Arizona taxpayers, but for the federal government as well. The facts speak for themselves:

- Arizona ranks third in the nation for the lowest cost per Medicaid enrollee; and
- Spends \$3,035 per member per year (nearly \$1,000 less than the national average among traditional Medicaid programs).

Arizona can be proud of its legacy of innovation in the field of healthcare delivery to low-income working families. AzHHA fully supports the AHCCCS Administration's waiver submittal. Thank you for this opportunity.

Sincerely,

John R. Rivers, FACHE  
President and Chief Executive Officer

Orig File  
XC: TR



# ARMA

ARIZONA MEDICAL  
ASSOCIATION

*Arizona Physicians Committed to Quality Care*

Leonard E. Ditmanson, MD  
*President*

Chic Older  
*Executive Vice President*

810 W. Bethany Home Rd. • Phoenix, AZ 85013-1699 • Tel: (602) 246-8901 • Toll-Free: (800) 482-3480 • Fax: (602) 242-6283 • [www.azmedassn.org](http://www.azmedassn.org)

February 3, 2006

Anthony D. Rodgers, Director  
Arizona Health Care Cost Containment System  
801 E. Jefferson St.  
Mail Drop 4100  
Phoenix, Arizona 85034

Dear Tony:

The Arizona Medical Association wishes to register its strong support of the pending AHCCCS waiver renewal.

It is our belief that AHCCCS is the finest Medicaid program in the United States and we pledge to help keep it viable in serving the AHCCCS eligible population. As I'm sure you know, few, if any, Medicaid programs in the country have as high a percentage of physician participation or greater access to providers to present their concerns or needs for change and to have them appropriately addressed.

For the record, we also support the additions to the waiver and would like to acknowledge the agency's competency in handling the high rate of program growth.

If we may be of assistance to AHCCCS in the process of renewing your waiver, please do not hesitate to contact us.

With kindest personal regards,

Cordially,

David Landrith, Vice President  
Policy and Political Affairs

cc: Leonard Ditmanson, M.D., President  
Anne Winter, Governor's Policy Advisor for Health  
January Contreras, Assistant Director, AHCCCS Intergovernmental Relations  
Chic Older, Executive Vice President

Orig. File  
XC TR

M. Zuhdi  
Jasser, MD  
*President-Elect*

R. Screven Farmer, III, MD  
*Vice President*

Mary E. Rimsza, MD  
*Secretary*

Beth A. Purdy, MD  
*Treasurer*

Jacqueline A. Chadwick, MD  
*AML Delegation Chair*

Philip E. Keen, MD  
*Immediate Past President*

Bruce A.  
Bethancourt, Jr., MD  
*Outgoing  
Past President*

Karla L. Birkholz, MD

Roberto P. Garcia, MD

Paula E. Nadell, MD



## MOUNTAIN PARK HEALTH CENTER

Sylvia Echave Stock  
President/CEO  
stock@mphc-ar.org

Corporate Office  
200 N. 1st Street  
Suite 400  
Phoenix, AZ 85004

March 1, 2008

MPHC Tucson  
200 N. 1st Street  
Tucson, AZ 85724

MPHC East Phoenix  
400 N. 1st Street  
Suite 400  
Phoenix, AZ 85004

Mr. Anthony D. Rodgers  
Director  
Arizona Health Care Cost Containment System  
801 E. Jefferson  
Phoenix, Arizona 85034

MPHC Maricopa  
400 N. 1st Street  
Suite 400  
Phoenix, AZ 85004

Dear Mr. Rodgers:

MPHC Maricopa/Phoenix  
400 N. 1st Street  
Suite 400  
Phoenix, AZ 85004

With this letter, we would like to express our support for the Arizona Health Care Cost Containment System as it seeks to renew its 1115 Research and Demonstration Waiver.

MPHC Tucson  
200 N. 1st Street  
Tucson, AZ 85724

Mountain Park Health Center is a federally funded community health center with over 25 years of experience in providing comprehensive primary health care to underserved communities throughout Maricopa County. Annually, we provide medical and dental care to more than 50,000 individuals, many of which are eligible for Medicaid and KidsCare. Our mission is to provide community responsive, culturally competent, comprehensive and exemplary health care to our entire community.

If you have any questions, please feel free to contact me at 602-323-3418.

Sincerely,

Sylvia Echave Stock  
President/CEO

cc: Attached is letter of support



March 7, 2006

Mr. Anthony Rodgers  
Director, Arizona Health Care Cost  
Containment System (AHCCCS)  
MD-4100  
801 E. Jefferson Street  
Phoenix, Arizona 85012

Dear Mr. Rodgers:

On behalf of Vanguard Health Systems, a national hospital company which owns and operates six hospitals in Arizona, I am writing in strong support of your agency's Section 1115 waiver application. Since 1982, the Arizona Health Care Cost Containment System has set the standard for statewide Medicaid managed care systems. Approval of the Section 1115 waiver by the Centers for Medicare and Medicaid Services permits AHCCCS greater flexibility in the management of the program to address the needs of the growing population of Arizona.

Vanguard recognizes that the innovative managed care model of AHCCCS is effective in both providing quality health care and controlling costs. As the first statewide managed health care program, AHCCCS continues to introduce constructive advancements and maintain standards of excellence that serve as a model for other states.

It is essential that modern health care systems be responsive and flexible. Because AHCCCS operates according to this imperative, it is prepared to meet the health care challenges associated with an increasingly complex health care delivery system and ever changing patient needs. We are confident that approval of the Section 1115 waiver will provide for the flexibility AHCCCS requires and Vanguard looks forward to working with AHCCCS to expand the delivery of quality health care to all Arizonans.

Best Regards,

A handwritten signature in black ink, appearing to read 'Reg Ballantyne'.

Reginald M. Ballantyne III  
Senior Corporate Officer

CC: Denise Smith, Centers for Medicare and Medicaid Services

# PROTECTING ARIZONA'S FAMILY

COALITION

2100 North Central Ave, Suite 225, Phoenix, Arizona, 85004  
[www.pafcoalition.org](http://www.pafcoalition.org)

March 7, 2006

Anthony D. Rodgers  
Director  
AHCCCS  
801 E. Jefferson  
Phoenix, AZ 85004

Dear Director Rodgers,

The Protecting Arizona's Family Coalition (PAFCO) is pleased to support Arizona's proposal to renew its 1115 Research and Demonstration Waiver. The Arizona Health Care Cost Containment System (AHCCCS) has developed a waiver proposal that will enable the agency to continue to provide quality health care to families in Arizona. The Protecting Arizona's Family Coalition supports this effort.

PAFCO is a diverse, non-partisan alliance involving hundreds of community services agencies, citizen advocacy groups, and faith-based organizations. The Coalition members include an estimated 20,000 staff, board members, and volunteers serving over 1.5 million people. One of the organization's top priorities is to advocate for health services. With this in mind, the organization appreciates the value that AHCCCS services provide in Arizona.

As you are aware, the approval of this proposal is central to the delivery of health care in Arizona. We are proud that Arizona's Medicaid program is respected on a national level and viewed as an innovative model. PAFCO is pleased to offer our support to the continuation of the program.

Sincerely,



Timothy J. Schmalz  
PAFCO Coordinator and Chief Executive Officer



March 8, 2006

Anthony D. Rodgers  
Director  
AHCCCS  
801 East Jefferson  
Phoenix, Arizona 85004

Dear Director Rodgers,

I am pleased to offer the support of the Children's Action Alliance as the Arizona Health Care Cost Containment System (AHCCCS) moves forward with renewing its 1115 Research and Demonstration Waiver. The Waiver has played an important role in Arizona by ensuring health insurance coverage to working families, and facilitating Arizona's innovative health care delivery model.

Children's Action Alliance is a non-profit, non-partisan research, education and advocacy organization dedicated to promoting the well-being of all of Arizona's children and families. The availability of health insurance for children in Arizona is one of the organization's highest priorities. Our organization has been deeply involved with health coverage issues over the years, acting as the Arizona grantee for the Robert Wood Johnson's Covering Kids and Families project.

I look forward to continuing to work with you to help Arizona meet the health care needs of children in our state. The renewal of the state's Waiver plays a central role in achieving this goal. Please advise if the Children's Action Alliance may offer any additional support as you work through the process of renewing the Waiver for an additional five years.

Thank you.

Sincerely,

Carol Karin  
President/CEO



---

ARIZONA'S VOICE ON MENTAL ILLNESS

---

March 10, 2006

Mr. Anthony D. Rodgers  
Director  
Arizona Health Care Cost Containment System  
801 E. Jefferson Street  
Phoenix, AZ 85004

Dear Director Rodgers,

NAMI Arizona (National Alliance on Mental Illness) is pleased to support Arizona's proposal to renew its 1115 Research and Demonstration Waiver. NAMI Arizona believes that the proposal developed by the Arizona Health Care Cost Containment System (AHCCCS) allows the agency to continue to provide vital health care to families in Arizona. The proposal is critical to the community of those with severe mental illnesses in Arizona.

NAMI Arizona is a 501(c) 3 whose mission is to educate, support and advocate for those with persistent brain disorders and their families. The organization is dedicated to the eradication of mental illness and to improving the quality of life of persons affected with mental illnesses and their families. Evidence-based educational programs and support groups are conducted at no charge throughout the state to assist families and those who receive services.

As you are aware, the approval of this proposal is central to the delivery of health care in Arizona. We are proud that Arizona's Medicaid program is respected on a national level and viewed as an innovative model. NAMI Arizona is supportive of the continuation of the program and believes it is essential.

Respectfully,

A handwritten signature in cursive script, appearing to read "Cheryl Weiner".

Cheryl Weiner  
Executive Director

---

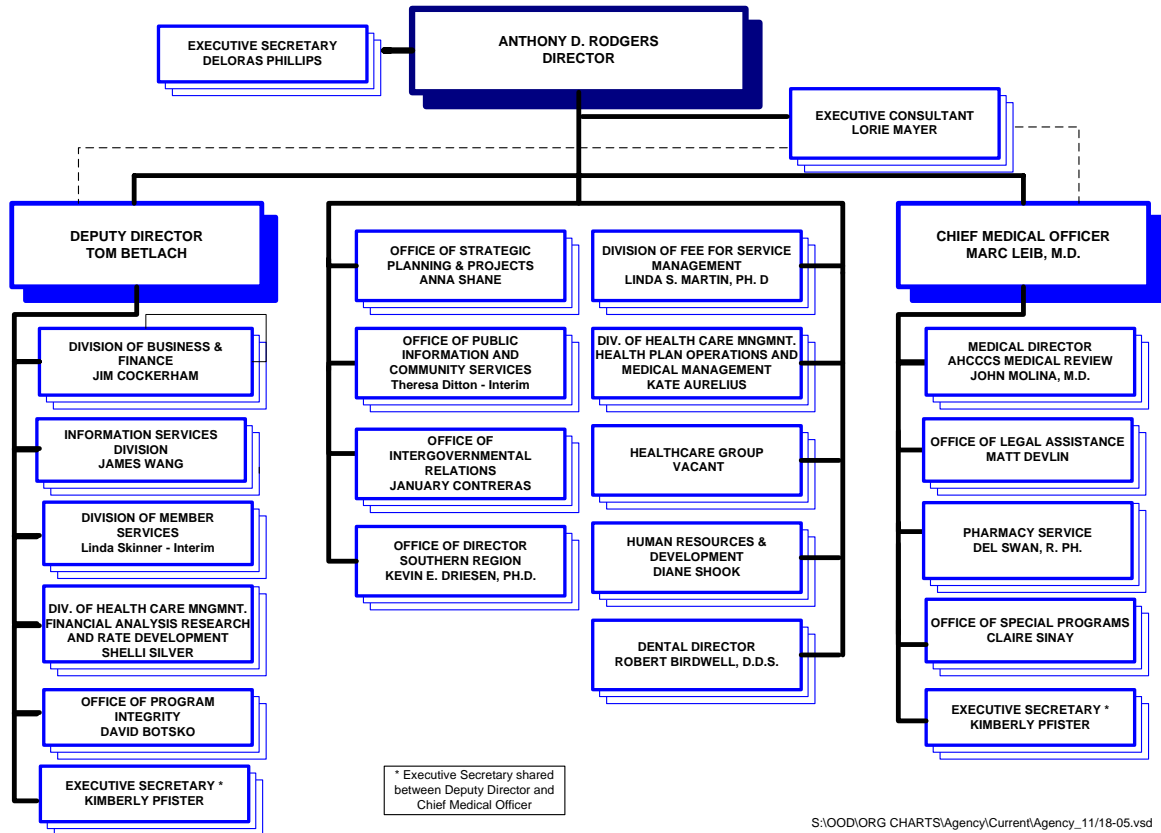
NAMI ARIZONA

*A State Affiliate of the National Alliance on Mental Illness Representing Ten Local NAMI Affiliates*  
1210 North Second Street • Phoenix, Arizona 85005-1684  
(602) 344-8166 • Toll Free: (877) 626-7622 • Fax: (602) 344-8364 • Website: [nami.az.org](http://nami.az.org) • Email: [weiner@nami.az.org](mailto:weiner@nami.az.org)

# Appendix III



## ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM Agency Organization



S:\OOD\ORG CHARTS\Agency\Current\Agency\_11\18-05.vsd

# Appendix IV

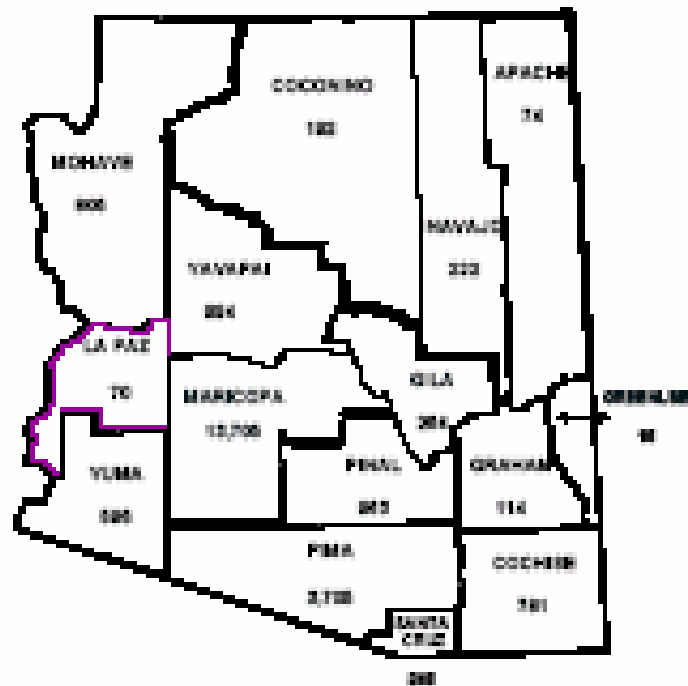
## GSA MAP

ALTCC EMerit and Physically Disabled Recruitment by County and GSA as of January 1, 2008

GSA Number	GSA Enrollment	GSA Counties
48	1,227	Preso, Gila
42	885	La Paz, Yuma
44	1,383	Apache, Coconino, Mohave, Navajo
46	188	Cochise, Graham, Greenlee
43	884	Yavapai
54	2,824	Pima, Santa Cruz
52	12,783	Maricopa

Total Program Contractor Enrollment  
= 22,729

\* Geographic Service Area



# AHCCCS Acute Enrollment by County and GSA\* As of December 1, 2002

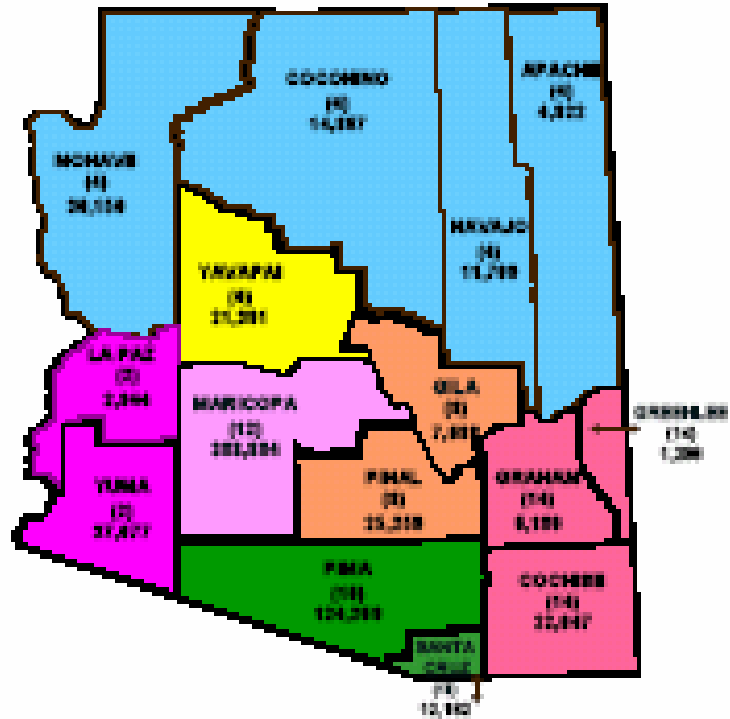
GSA Number Health Plan Enrollment

2	38,821
4	61,540
6	21,321
8	32,547
10	136,451
12	388,884
14	28,515

Total Health Plan Enrollment = 716,657

\* Geographic Service Area  
(indicated on map in parentheses)

Source: AHCCCS Acute Enrollment Report



# Appendix V

## ALTCS Premium



***Our first care is your health care***  
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

***Janet Napolitano, Governor***  
***Anthony D. Rodgers, Director***

801 East Jefferson, Phoenix AZ 85034  
PO Box 25520, Phoenix AZ 85002  
**phone** 602 417 4000  
[www.ahcccs.state.az.us](http://www.ahcccs.state.az.us)

December 1, 2003

Joan Peterson, Ph.D., Project Officer  
CMS, CMSO/FCHPG/DIHS  
7500 Security Blvd.  
Mail Stop S2-01-16  
Baltimore, Maryland 21244-1850

Dear Joan:

On May 2, 2003, AHCCCS submitted a formal request for CMS' approval of waiver and expenditure authority in order to implement new cost sharing requirements for traditional Medicaid and expansion populations. On June 17, CMS provided clarification on some of the issues and offered technical assistance to help us work through the remaining issues.

As we discussed, the legislature expects us to implement as many of the cost sharing proposals as we can and have reduced our budget in anticipation of the revenue from these new cost sharing measures. Before we can implement the outstanding cost sharing proposals, we need approval from CMS. I would like to set up a conference call this week to resolve outstanding issues so we can inform the legislature of our progress. I am providing a list of the outstanding issues to help guide our discussion.

- Approval of Chapter V of the Operational Protocol pertaining to cost sharing submitted on October 6, 2003.
- Approval of the pending Medicaid and SCHIP State Plan Amendments on cost sharing.
- Response to our August 12, 2003 question about the permissibility of imposing a deductible, as required by state law, on households with developmentally disabled children who are enrolled in ALTCS.
- Guidance on the five percent cap on out-of-pocket expenses under SCHIP. Currently, HIFA II parents with income between 100-150% of FPL do pay a monthly premium. We need guidance on whether these monthly premiums must be calculated as part of the five percent cap on out-of-pocket expenses if the state were to impose a new monthly premium on SCHIP children in households with income between 100 to 150% of the FPL.

Joan Peterson  
December 1, 2003  
Page 2

- Do the restrictions contained in 42 CFR 447.52 apply to the maximum amount of premiums that can be assessed on HIFA II parents with income between 100 and 150% of the FPL?
- Discussion of a forthcoming State Plan Amendment to increase the monthly premiums for SCHIP children in households with income above 150% of the FPL. We will submit a State Plan Amendment to make this effective on February 2, 2004.
- Approval of the waiver and expenditure authority to impose monthly premiums on households with children enrolled in ALTCS. Below is a modification of the proposal that was submitted in May 2003. The major difference is that AHCCCS has raised the household income level that would be subject to a monthly premium and we have provided more detail on the proposed methodology.
- CMS is also reviewing copayment policies for HIFA I and II Native Americans enrolled in a health plan.

#### Monthly Premiums for ALTCS Eligible Children

Currently, AHCCCS does not count parental income when determining ALTCS eligibility for a child under the age of 18. AHCCCS does not want to limit enrollment in ALTCS by imposing an income test at the time of initial application but wants parents with higher income levels to contribute to the cost of care. Therefore, we are requesting waiver and expenditure authority to impose a monthly premium on all households with adjusted gross income at or above 400% of the FPL that have children under the age of 18 with physical or developmental disabilities enrolled in ALTCS.

The monthly premium would be two percent of the annual adjusted gross income for households with income between 400 and 500% of the FPL and four percent for households with income at and above 500% the FPL. There will be no distinction between institutional or non-institutional placements. AHCCCS will compute the premium amount using annual adjusted gross income from the parent's most recent federal income tax return (for example, line 35 of 2002 1040, line 21 of 1040A, or line 4 of 1040EZ). During the application process for new individuals, parents will be required to provide the previous year's tax return or income verification, as a condition of the child's eligibility for ALTCS.

If parents do not have a tax return or report a significant increase or decrease in income (e.g. loss of employment or change in jobs) the parents will provide verification with an employer's statement, self-employment records or other best available information. Premiums will be billed monthly on the first and due on the 15<sup>th</sup>.

AHCCCS will establish a grievance and appeal process allowing families to dispute the initial amount of the premium based on annual income or family size, increases in premiums and discontinuances for failure to pay the monthly premiums. Premiums will continue to be billed and incurred during an eligibility appeal period and failure to payment the premium during the appeal period could mean a loss of eligibility. If the appeal is based on an increase in the premium amount, the premium increase will not be imposed until after an appeal decision.

Wendy will call today to see when we can set up a conference call. If you have any questions, please call me at (602) 417-4447.

Sincerely,

Lynn Dunton  
Assistant Director

S:\OPC\LRD\Cost Sharing\Dec 1 letter on cost sharing.doc

# Appendix VI

## Disregard of Interest



***Our first care is your health care***  
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

***Janet Napolitano, Governor***  
***Anthony D. Rodgers, Director***

801 East Jefferson, Phoenix AZ 85034  
PO Box 25520, Phoenix AZ 85002  
**phone 602 417 4000**  
[www.ahcccs.state.az.us](http://www.ahcccs.state.az.us)

March 17, 2005

Joan Peterson, Ph.D., Project Officer  
CMS/FCHGP/DIHS  
7500 Security Boulevard  
Mail Stop S2-01-16  
Baltimore, Maryland 21244-1850

Dear Joan:

In order to simplify the eligibility process and save administrative costs, Arizona is seeking expenditure authority to disregard interest and dividend income from excluded resources for ALTCS and SSI-MAO eligibility determinations. Prior to July 1, 2004, any income or dividends from resources that were either countable or excluded by federal law were used to calculate an individual's income level for the purposes of SSI-cash, SSI-MAO and the federal benefit rate for long term care.

This requirement changed on July 1, 2004, when The Social Security Protection Act became law. Intended to simplify the eligibility process and eliminate needless complexity, Congress excluded interest or dividend income from countable resources. However, the federal law did not make a similar change to exclude interest or dividend income from resources that are excluded under Section 1613(a) when determining eligibility for the SSI. As a result, interest and dividends earned on countable resources are excluded as income while interest and dividends from excluded resources are counted as income.

Joan Peterson  
March 17, 2005  
Page 2

AHCCCS would like to exclude the interest and dividend income from those resources excluded under 1613(a) of the Act. This exclusion would apply to the following eligibility groups:

- ALTCS under 1902(a)(10)(A)(ii)(V).
- The Pickle Amendment Group under 42 CFR 435.135.
- The Disabled Adult Child under Section 1634(c).
- Disabled Children under Section 1902(a)(10)(A)(i)(II).
- The Disabled Widow/Widower group under Section 1634(d).

Considering the small amount of interest or dividend income that would be counted as income from the sources listed above, AHCCCS believes the fiscal impact would be negligible. The real benefit will be in the simplification of the eligibility process and removing some of the complexity from the income determination process.

If you have any questions, please call me at (602) 417-4483.

Sincerely,

A handwritten signature in dark ink, appearing to read 'T. Betlach', with a stylized flourish at the end.

Thomas J. Betlach  
Deputy Director

## Appendix VII

# Employer Sponsored Insurance

*AHCCCS Proposal to Implement an  
Employer Sponsored Insurance Program*

## ***Employer Sponsored Insurance Program***

### **Overview**

In response to the Terms and Conditions of the HIFA Waiver, the Arizona Health Care Cost Containment System (AHCCCS) will implement an Employer Sponsored Insurance (ESI) program. Under the program, AHCCCS will provide premium subsidies for the purchase of employer sponsored health insurance.

The basic parameters of the ESI program are:

- The program will be implemented statewide
- The program will be available to eligible employees of small businesses only; not family members
- No additional benefits (e.g. wraparound coverage) will be provided to individuals enrolled in the ESI program.
- ESI members will be required to pay cost sharing (e.g., deductibles, co-payments) if required by their employer sponsored plan and may also be required to pay a portion of their monthly premium. Out-of-pocket expenses will not be capped.

### **General Program Design**

#### **Eligible Population**

The population eligible for the ESI program will be individuals who have a family income that does not exceed 200% of FPL and who have access to qualified employer sponsored insurance coverage. Gross income will be used to determine eligibility, excluding income not earned as an employee or received for purposes other than having provided a service as provided under 20 CFR Part 416. An asset test will not be required. The ESI program is only available to U.S. citizens and legal residents who qualify for full services.

#### **Qualified Employer Sponsored Coverage**

Qualified employer sponsored insurance will include coverage provided through Healthcare Group of Arizona (HCG) or through any other commercial group package offered by the employer. The commercial group coverage must include a basic primary care package (e.g., health care services customarily furnished by and through a general practitioner, family physician, pediatrician) offering the following services:

- Inpatient hospital services
- Outpatient services

- Physician's surgical and medical services
- Laboratory and X-ray services
- Pharmacy services.
- (Note: behavioral health services, dental and vision services and non-emergency transportation coverage would not be a mandatory service)

All eligible employers must meet the following requirements:

- The employer must contribute at least 50% of the balance of the premium after application of the subsidy.
- The employer must have between 2 and 25 employees.

### **Enrollment Requirements**

Eligibility determination for ESI will be:

- Completed as part of the AHCCCS application process. For potentially eligible members, information will be obtained from their employer about available employer health care coverage. If employer sponsored health care coverage is available, enrolling in ESI will be explained to the applicant. AHCCCS will make members aware of the ESI option.
- Annual re-determinations, unless the enrollee is no longer eligible for ESI prior to the end of the 12-month period.

For those who meet the ESI eligibility requirements, enrollment into the ESI program will:

- Be optional for all Title XIX and XXI eligible members.
- Include a 12 month lock-in. The following are exceptions to the 12 month lock-in period:
  - The person is no longer employed by a company offering coverage (e.g., leaves employment, laid off or retires, employer drops coverage);
  - The parameters of the employer plan change so it no longer meets the employer sponsored coverage requirements or creates undue financial hardship for the person (e.g., increase in deductible, copayments);
  - The person becomes eligible for the traditional Title XIX program and opts to enroll into the Medicaid program;
  - The person becomes eligible for a Title XXI program and opts to enroll into the HIFA Waiver program;
  - The person no longer lives in the state;

- The person wants to disenroll from the ESI Program; or
- The ESI program is no longer an available option under AHCCCS.

Even though a person may terminate enrollment from the ESI program, AHCCCS cannot control whether or not the commercial insurance can be terminated outside of open enrollment. Applicants will be educated when making the decision to enroll in the ESI program that AHCCCS will not reimburse the employee's portion of the premium for commercial insurance for the same time period that a person is enrolled in another AHCCCS program.

- Persons will be disenrolled from the ESI program if:
  1. The person becomes ineligible by exceeding income standards; or
  2. AHCCCS does not receive verification of employer coverage for the person; or
  3. The person knowingly misrepresents themselves or fails to reports certain changes in employer sponsored coverage status.

Employers will be encouraged to waive "waiting periods" by making ESI eligibility a qualifying event and allowing an eligible ESI person to immediately enroll in the employer sponsored health plan. If the applicant does not want to wait for the employer's open enrollment period, the individual can apply for Medicaid/SCHIP coverage.

### **Premium Subsidy Payments**

At this point, it is envisioned that the state will pay a monthly amount of \$150 per member per month for coverage.

For those enrolled in the ESI program, AHCCCS will directly reimburse the insurance carrier for the subsidized portion of the premium costs.

For those ESI enrollees who are not covered under HCG, AHCCCS will require electronic verification from commercial carriers providing coverage to show payment of health care coverage. (Note: Under HCG, employers are required to notify AHCCCS when an employee is no longer covered).

### **Enrollment**

Enrollment projections for the program are very preliminary. The state estimates that if the program is approved and implemented in FY2007, enrollment could approach 11,000 by September 30, 2008. These are very preliminary estimates and certainly could be impacted by the final scope of the overall program.

### **Enrollment Limitations**

AHCCCS may cap enrollment in the ESI program based on availability of funding.

**Program Evaluation/ Accountability and Monitoring**

There will be an evaluation component, including an interim evaluation at the end of the second year of the program, to determine if the program has been cost effective. The evaluation will consider: 1) the aggregate costs for enrollees in the ESI program for private health insurance coverage as opposed to the costs that would have been incurred if they had been enrolled with an AHCCCS health plan, and 2) changes in employer contribution levels.

Data elements to be collected and reported include premium costs (enrollee share and state subsidy), subsidy costs and employer contributions.

**Budget Neutrality**

The costs of the program will be included in the state's overall budget neutrality estimates.

**Program Costs**

As depicted in the table below, the AHCCCS program is estimating the total fund costs of the ESI program to be \$128.25 million during the next five years. This is based on a population that would grow at 500 new members per month over the course of the waiver renewal term. Current estimates indicate that as many as 70,000 individuals in the state may be eligible for the program. The estimated costs associated with this waiver proposal fit within the estimated budget neutrality limits that are established for the baseline program in another chapter of this document.

ESI Estimates (In thousands)						
	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	Totals
Enrollment (9-30)	5,000	11,000	17,000	23,000	29,000	
Annual Cost	4,050.0	14,850.0	25,650.0	36,450.0	47,250.0	128,250.0
General Fund	1,336.5	4,900.5	8,464.5	12,028.5	15,592.5	42,322.5
Federal Fund	2,713.5	9,949.5	17,185.5	24,421.5	31,657.5	85,927.5

**Waiver and Expenditure Authority Requested**

Waiver authority is requested pursuant to the authority of §1115(a)(1) of the Social Security Act: Amount, Duration, and Scope 1902(a)(10)(B)

- To permit the provision of different benefit packages to different populations in the demonstration. Benefits (i.e., amount, duration and scope) may vary by individual based on eligibility category.

Expenditure authority is requested under §1115(a)(2) of the Social Security Act to allow the following expenditures which are not otherwise included as expenditures under §§1902 or 2105, to be regarded as expenditures under the State's Title XIX or Title XXI plan:

- Expenditures to provide services, including premium assistance, to populations not otherwise eligible to be covered under the Medicaid State Plan.
- Expenditures to provide services to populations not otherwise eligible under a State child health plan.
- Expenditures that would not be payable because of the operation of the limitations at 2105(c)(2) because they are not for targeted low-income children.